Supreme Court, U.S.
FILED

961824 MAY 16 1997

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No. 96-_____

In the
Supreme Court of the United States
October Term, 1996

GARY LEE, M.D., individually and on behalf of his terminally ill patients; WILLIAM PETTY, M.D., individually and on behalf of his terminally ill patients; JANICE ELSNER, individually and as representative of a class of terminally-ill patients; et al.,

Petitioners,

v.

DOUGLAS F. HARCLEROAD, et al.,

Respondents.

On Petition for a Writ of Certiorari to the
United States Court of Appeals for the Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Janice Elsner is dying. Recurring clinical depression makes her vacillate between wanting suicide and life. Oregon's Measure 16 imposes lower medical, psychiatric, and intervention standards if she seeks suicide assistance than non-terminally ill suicidal persons possess. Does Janice have standing to challenge Measure 16 on equal protection, due process, and statutory grounds, both individually and as representative of a class?

2. Drs. Gary Lee and William Petty assert their terminally-ill patients' interests in equal protection, due process, and statutory challenges to Measure 16, but the appeals court held they had no standing because their patients would be "no closer to suffering the asserted injury than Elsner." May these physicians assert third party standing?

3. Health care providers claim Measure 16 violates their rights to freedom of religion and association by requiring forced participation in and association with assisted suicide. The appeals court decided they had no standing and their claim was not ripe because they were subject to no penalty for refusal to participate, but there are serious penalties. Do the health care providers have standing to challenge Measure 16 and is their challenge ripe?

LIST OF PARTIES

Petitioners:

- Gary Lee, M.D., individually and on behalf of his terminally ill patients,
- William Petty, M.D., individually and on behalf of his terminally ill patients,
- Janice Elsner, individually and as representative of a class of terminally-ill patients,
- Fritz Beck,
- June Beck,
- The Willows Home, Inc.,
- Sister Geraldine Bernards, individually and as Administrator of Maryville Nursing Home, Inc., and
- Maryville Nursing Home, Inc.

Respondents:[1]

- Douglas F. Harcleroad, in his official capacity as the District Attorney for Lane County, Oregon, and as representative of the class of all district attorneys in the State of Oregon,
- Members of the Oregon Board of Medical Examiners,
- Peter Goodwin (intervenor),
- Barbara Coombs Lee (intervenor),

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[1]The members of the Oregon Board of Medical Examiners are listed by office only. S. Ct. Rule 35.4. They were listed in the lower courts as follows: Terry L. Connor, D.O., in his official capacity as Chairman of the Oregon Board of Medical Examiners; Edward a. Heusch, in his official capacity as Vice-Chairman of the Oregon Board of Medical Examiners; Catherine M. Nater, in her official capacity as Secretary of the Oregon Board of Medical Examiners; and John W. Gregsby, M.D., Sarah S. Hendrickson, M.D., George a Porter, M.D., James H. Sampson, M.D., Rosemary C. Lee Selinger, M.D., Fred R. Stark, M.D., Maralyn E. Turner, M.D., and J. Bruce Williams, M.D., in their official capacity as members of the Board of Medical Examiners.

- Elven Sinnard (intervenor),
- Ted Levin, M.D. (intervenor), and
- Tim Schuck (intervenor).

LIST OF CORPORATIONS

The Willows Home, Inc. has no parent company and no subsidiaries.

The parent company of Maryville Nursing Home, Inc. is Sisters of St. Mary of Oregon, an Oregon nonprofit religious corporation. Maryville Nursing Home, Inc. has no subsidiaries.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners respectfully request a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS AND ORDERS BELOW

The order of the court of appeals denying rehearing is unreported. App. 67a. The opinion of the court of appeals vacating and remanding the district court decision is reported at 107 F.3d 1382. App. 1a.

The order of the district court granting declaratory judgment and permanent injunction is reported at 891 F. Supp. 1439. App. 35a. The opinion of the district court containing its equal protection analysis is reported at 891 F. Supp. 1429. App. 37a. The opinion of the district court containing its standing analysis is reported at 891 F. Supp. 1421. App. 56a. The opinion of the district court granting a preliminary injunction is reported at 891 F. Supp. 1429.

JURISDICTION

The opinion and judgment of the court of appeals was filed on February 27, 1997. App. 1a. Petitioners Lee et al. filed a timely petition for rehearing. App. 72a. Rehearing was denied on April 11, 1997. App. 67a. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL & STATUTORY PROVISIONS

Article III, Section 2, of the Constitution of the United States of America reads in pertinent part: "The judicial Power shall extend to all Cases, in Law and Equity, arising under this Constitution, the laws of the United States, and Treaties made, or which shall be made, under their Authority . . . ."

Oregon's 1994 Ballot Measure 16, entitled "The Oregon Death with Dignity Act," is set forth as an appendix to the court of appeals opinion. App. 20a.

STATEMENT OF THE CASE

Janice Elsner is dying from progressive muscular dystrophy. Recurrent clinical depression makes Janice vacillate between wanting suicide and life.[2] *See infra.*

Janice has an imminent and substantial risk of death if Oregon's Ballot Measure 16 (authorizing assisted suicide) goes into effect because it doesn't even require psychiatric examination for depression if persons request suicide assistance. If persons not terminally ill request suicide assistance, they are immediately subject to crisis intervention and civil commitment for evaluation and treatment by a mental health professional. This squares with the scientific reality that nearly all persons seeking suicide do so because of depression. Suicidologists say this is also true of terminally ill persons: nearly all who are suicidal will no longer be so if their depression is treated. *See infra.*

Oregon thinks assisted suicide poses such serious dangers to its citizens that it bans it for everyone in Oregon — except for terminally ill persons like Janice, who are highly subject to suicidal depression. Measure 16 imposes lower medical, psychiatric, and intervention standards if Janice seeks suicide assistance than non-terminally ill suicidal persons possess. *See infra.*

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[2]Another terminally-ill plaintiff, Eric Dutson, has already died of AIDS. Dutson also had a history of recurrent clinical depression.

A. Measure 16

Measure 16 was narrowly enacted by Oregon voters on November 8, 1994. It created a scheme of state-authorized, state-regulated, physician-assisted suicide, purportedly limited to terminally-ill, "capable," adults. § 2.01; App. 22a. The entire scheme is set out in the Appendix. App. 20a. The "safeguards" intended to limit assisted suicide to the "capable" are set out in Section 3 of Measure 16. App. 24a.

Conspicuously absent are *any* safeguards at the most critical time, when the lethal prescription is *consumed*. The lethal prescription may be consumed days, weeks, or months after it is obtained, and no effort is made to assure mental competence, to ascertain that the prognosis of death within six months is yet accurate, or to prevent undue influence or coercion.

For the time when the lethal prescription is *dispensed*, certain "safeguards" apply. The evaluation of whether a patient has a "terminal disease" and is "capable" is made by the "attending physician." § 3.01; App. 24a. Confirmation of these diagnoses is made by a "consulting physician" chosen by the "attending physician." § 3.01; App. 24a. These persons making psychiatric or psychological evaluations are primary-care physicians. There is no requirement that a psychiatrist or psychologist make the diagnosis of whether a suicidal person "may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment." § 3.03; App. 25a. The request for a lethal prescription must be in writing, witnessed by two persons, neither of whom is required to be a mental health professional. § 2.02; App. 23a. There is no requirement that family members — or a court-appointed guardian — be notified, although the patient is invited to contact her family. § 3.05; App. 26a. Fifteen days must elapse between the patient's first oral request for suicide assistance and the writing of the lethal prescription, and within this time 48 hours

must elapse between the written request and writing of the prescription. § 3.08; App. 27a.

Lowered standards of care are created by Measure 16, for the purpose of inducing physicians to participate in the scheme. Appellants' Brief at 20, *Lee v. Oregon*, 107 F.3d 1382. Although physicians are ordinarily subject to the prevailing objective standard of medical care, *see infra*, physicians assisting suicidal persons who are terminally ill need only meet a subjective, "good faith" standard of care. § 4.01; App. 30a. This reduced standard of care applies to the diagnoses of whether a person is terminally ill (having less than six months to live)[3] and whether she is "capable," as well as to the effectiveness of the lethal prescription (which could leave the patient badly damaged and in a coma instead of dead).[4] The protections for the physician extend to: (1) "civil or criminal liability or professional disciplinary action" and (2) "censure, discipline, suspension, loss of license, loss of privilege, loss of membership or other penalty" by any "professional organization or association, or health care provider." § 4.01; App. 30a.

A conscience exemption is provided in Measure 16, but it applies only "to participat[ion] in the provision to a qualified patient of medication to end his or her life." § 4.01; App. 30a. By its terms, it applies only to the actual act of providing the lethal prescription, not myriad other types of complicity in

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[3]There is evidence in the record that it is extremely difficult for a physician to accurately diagnose whether a patient has less than six months to live, and misdiagnoses are common. *Affidavit of Richard Fenigsen, M.D., Ph.D.* Thus, many will "qualify" for assistance in suicide who have an extended lifespan remaining, and tragically premature deaths will occur.

[4]There is evidence in the record that 25% of the suicides by the oral ingestion of lethal substances that Measure 16 prescribes will fail, raising the specter of patient coma, renal damage, toxic psychosis, serious central nervous system damage, and protracted suffering for the patient and her family. *Affidavit of Jerome R. Wernow.*

assisted suicide. For example, a physician would be required to advise qualified patients of this option or suffer a variety of penalties and a religious nursing home would be required to permit assisted suicide in its facility and even provide a witness despite religious objections. § 2.02(4); App. 23a.

B. Proceedings Below

On November 23, 1994, fifteen days before Measure 16 was scheduled to go into effect, plaintiffs filed suit. The claims were brought under 42 U.S.C. § 1983, and jurisdiction was invoked under 28 U.S.C. § 1343.

Concerned about the risk to her life and her second-class status under Measure 16, Janice Elsner challenged the law for violating her federal equal protection and due process constitutional rights (Fourteenth Amendment), as well as the Americans With Disabilities Act of 1990 (42 U.S.C. § 1201 et seq.) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 791 et seq.).

Janice was joined in the suit by Drs. Gary Lee and William Petty, who asserted the rights of their terminally patients under the same theories used by Janice Elsner. Also joining in the suit were two residential care facilities, The Willows Home, Inc. and Maryville Nursing Home, Inc., as well as administrators of the facilities, Fritz and June Beck and Sister Geraldine Bernards. All of these health and residential care providers alleged that Measure 16 violates their rights to freedom of religion (under both the First Amendment and Religious Freedom Restoration Act of 1993, § 2000bb et seq.) and association (First Amendment) by requiring forced participation in and association with assisted suicide.

On December 27, 1994, the district court granted preliminary injunctive relief to plaintiffs. *Lee v. Oregon*, 869 F. Supp. 1492. On August 3, 1995, the district court granted summary judgment to plaintiffs and entered a declaratory judgment and

a permanent injunction against implementation of Measure 16. App. 35a. The district court held that Measure 16 violated the Equal Protection Clause and enjoined defendants from recognizing the constitutionality of Measure 16 in their enforcement decisions. *Id.*

The district court devoted an entire opinion to its equal protection analysis. App. 37a. It did not reach plaintiffs' other claims because it found equal protection sufficient to resolve the case. App. 53a. The trial court issued another, separate opinion on standing. App. 56. It found that Janice Elsner had standing to challenge the Act because she suffered an actual and imminent injury under Measure 16, including a risk of death and present lowered standards of care for terminally-ill persons who might seek assistance in suicide. App. 59a-62a, 66a. It held that Dr. Petty, Maryville Nursing Home, Sister Geraldine Bernards, The Willows Home, and Fritz and June Beck had standing to raise First Amendment and Religious Freedom Restoration Act claims. App. 66a. It held that Drs. Lee and Petty did not have standing to raise claims on behalf of their patients. App. 63a-64a. In a separate order, the district court dismissed as moot plaintiffs' motion to certify a class of terminally-ill persons.

The respondents before this Court appealed to the Ninth Circuit Court of Appeals. Petitioners cross-appealed the denial of third-party standing for the physicians to represent the rights of their terminally-ill patients and the denial of class certification.

On February 27, 1997, the Ninth Circuit reversed the district court on standing grounds, holding that no plaintiff had standing to challenge Measure 16. App. 1a. Specifically, the Ninth Circuit held that Janice Elsner had not "made an *individualized* showing that there was a very significant possibility that the future harm will ensue." App. 12a (emphasis in original; internal quotation marks omitted). It decided that Drs. Lee and Petty could not assert the rights of their terminally-ill patients

because their patients would be "no closer to suffering the asserted injury than Elsner." App. 15a. The Ninth Circuit decided that Dr. Petty and residential care providers did not have standing "because Measure does not provide any penalty, criminal or otherwise, for a violation of the challenged provisions." App. 18a. For the same reason the appellate court decided these Plaintiffs' case was not ripe, i.e., "because Plaintiffs have not identified any hardship that would befall them if their claims were not considered at this time." App. 18a. The Ninth Circuit rejected the cross appeal for certification of a class of terminally-ill persons on the basis that Janice Elsner did not have standing herself. App. 15a.

On March 13, 1997, Elsner et al. filed a timely petition for rehearing, focusing at length on standing and indicating matters overlooked by the court of appeals. App. 72a. On April 11, 1997, the Ninth Circuit denied the petition for rehearing. App. 67a.

The mandate did not issue on April 18, 1997, as scheduled, because the Ninth Circuit granted a stay of the mandate for thirty days to allow filing of the present petition and thereafter until the conclusion of this Court's consideration of the case.

REASONS FOR GRANTING THE PETITION

I. This case involves matters of great public importance that have not been, but should be, settled by this Court.

This case involves issues of immense personal and public importance:

1. Whether Janice Elsner will be protected from unwanted death;
2. Whether Janice Elsner will have her day in court to challenge Oregon's Measure 16, which

(a) immediately strips her of presumptions about and protections from suicide and assistance in suicide which are enjoyed by Oregon residents who are not terminally ill and puts her at imminent and substantial risk for unwanted death,

(b) immediately strips her of the medical standard of care afforded persons not terminally ill, by imposing a lower, good-faith, subjective standard, and

(c) immediately strips her and her estate of legal redress available to persons not terminally ill, by imposing a lower, good-faith, subjective standard;

3. Whether a state has an equal protection duty to protect terminally ill persons from unwanted death to the same extent it protects persons who are not terminally ill; and

4. Whether health care providers have standing to challenge Measure 16 for immediately forcing them into complicity with assisted suicide against their consciences by a variety of types of required participation in assisted suicide. Under Measure 16, there is no protection from criminal, disciplinary, and malpractice liability for refusal to participate in actions such as advising a patient of the option of assisted suicide in the informed consent dialogue.

From a broader perspective, this case is "certworthy" because it involves two "important question[s] of federal law that ha[ve] not been, but should be, settled by this Court," S. Ct. Rule 10 (c):

1. May a state create a state-authorized and regulated scheme of assisted suicide, and, if so, what minimal safeguards are necessary to protect the constitutional rights of terminally ill persons and for the statute to pass constitutional scrutiny at any level? If this Court determines that Janice Elsner or another plaintiff has stand-

ing, it may decide this underlying issue of the constitutionality of Measure 16, if it chooses.

2. May a state-authorized regime of assisted suicide be challenged for constitutionality, and, if so, by whom?

As to the underlying assisted suicide issue, it is a life-and-death issue for Janice Elsner, as it is for all terminally-ill persons in Oregon who are at risk for unwanted death as a result of undiagnosed, suicidal depression and are stripped of protections afforded others not terminally ill. It is especially a life-and-death issue for terminally-ill persons who have recurring suicidal depression, as Elsner does. Physician assisted suicide is a vital issue for the United States of America because this is the first venture of a state into an area which has been off limits for over two millennia, since the widespread adoption of the principle underlying the Hippocratic Oath.

While this Court has before it two cases involving assisted suicide, neither governs the present case. Both *Washington v. Glucksberg*, No. 96-110, and *Vacco v. Quill*, No. 95-1858, involve assertions that the states must permit assisted suicide as a constitutional right. Regardless of the outcome of those cases, this case is the next logical consideration.

If there *is* a constitutional right to assisted suicide, may states implement a regime of state-authorized assisted suicide in such a way as to violate the right of terminally ill persons to the equal protection of the laws by putting them at unreasonable risk for unwanted death?

If there is *no* constitutional right to assisted suicide, is the right to life guaranteed by the Fourteenth Amendment alienable, or is it inalienable, like the freedoms against slavery, cruel and

unusual punishment, and government established religion?[5] If the right to life may be alienated and states may permit assisted suicide, are there minimal protections which must be afforded persons in order for the state-authorized scheme to meet scrutiny for rationality? If a state sets for itself the goal of Measure 16, to allow only "capable" persons to have help in killing themselves, is it constitutionally relevant that the "safeguards" purporting to screen out persons not mentally "capable" are wholly inadequate and ineffective — and wholly absent at the subsequent, critical time when the lethal prescription is taken? May a state-endorsed and regulated assisted suicide scheme ignore the findings of modern suicidology and operate on irrational stereotypes? May states create lower standards of medical care for persons within the class defined, as Oregon has done?

As to the question of who, if anyone, may challenge a state-imposed assisted suicide regime, that issue is of equally significant national importance. This Court has held that "[t]he assumption that if respondents have no standing to sue, no one will have standing, is not a reason to find standing." *Valley Forge Christian College v. Americans United for Separation of Church and State*, 454 U.S. 464, 489 (1982) (quoting *Shlesinger v. Reservists Committee to Stop the War*, 418 U.S. 208, 227 (1974). But it would be truly anomalous if states may pass assisted suicide statutes stripping terminally ill persons of presumptions and protections against self harm and legal remedies for medical malpractice or misfeasance enjoyed by

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[5]*Cf. Roe v. Wade*, 410 U.S. 113 (1973) ("If this suggestion of personhood is established, the appellant's case [for a right to abortion], of course, collapses for the fetus' life would then be guaranteed specifically by the [Fourteenth] Amendment."). The freedoms listed protect against harm, and consent is neither a defense nor a relevant consideration. If the right to life is inalienable, then Measure 16 must be examined under strict scrutiny, although it does not even pass rational basis equal protection review.

others, yet no one could challenge those statutes. As developed more fully in the following section, the Ninth Circuit takes the untenable position that persons must be in the throes of suicidal depression and seeking assistance in killing themselves before bringing suit (an impossible situation), or tragic deaths must occur and actions be initiated by the estates of the deceased. The very depression that would make Elsner seek assisted suicide would keep her from filing a challenge to Measure 16 while in a suicidal depression. Absent psychiatric examination and notification of her next of kin (neither required by Measure 16), there would be no one to help her with her depression and represent her legal interests.[6] Under the Ninth Circuit's analysis, she will never get her day in court to challenge the statute which poses such a serious risk to her.

Standing should be sufficient where, as a result of the state official defendants' decision to recognize Measure 16 as constitutional and implement it by failing to enforce the penalties for violating the general ban on assisted suicide, Janice Elsner is in imminent and substantial peril for her life and stands currently stripped of protections and presumptions afforded others in Oregon. Tragedy should not be the ticket to constitutional review of Measure 16 — a review too late to help the victim of unwanted (but for suicidal depression) assisted suicide.

These are the issues raised by this case, and they are of vital national importance as the debate over assisted suicide continues. Because the settled practice of over two millennia and the lives of myriad vulnerable persons are at stake, state-sanctioned

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[6]The district court noted the absence of any court supervision of the assisted suicide process, although such supervision is required for non-terminally-ill persons who seek self-harm and are confined for extended treatment by mental health professionals. App. 46a.

death of innocent persons should not begin without the most careful review by this Court.

II. Janice Elsner is entitled to her day in court.

In Oregon, those not terminally ill enjoy a wide range of protections from self harm, assistance in suicide, and substandard medical care. These protections include a criminal statute barring assisted suicide,[7] a statute barring the use of consent as a defense to manslaughter (or any crime),[8] a statute authorizing use of reasonable force to prevent another from committing suicide or any self harm,[9] a statute authorizing civil commitment and evaluation by a mental health expert for those seeking suicide,[10] an objective and general standard of medical care with legal redress for medical malpractice not measuring up to the general and objective standard of patient care,[11] and care from physicians subject to discipline for not measuring up to objective and general medical standards.[12] As shall be seen, these protections are not available to the terminally ill under Measure 16, even if they have recurring bouts of suicidal depression.

By its general statutory scheme protecting people not terminally ill from self harm and assistance in suicide, Oregon has operated on the discovery of modern psychiatry that "sane

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[7]Or. Rev. Stat. § 163.125 (assisted suicide is second degree murder). By making it a crime, Oregon declares that assisted suicide "unjustifiably and inexcusably inflicts . . . substantial harm to individual [and] public interests." Or. Rev. Stat. § 161.025(1)(b).

[8]Or. Rev. Stat. § 163.117.

[9]Or. Rev. Stat. § 161.205.

[10]Or. Rev. Stat. § 426.070 et seq.

[11]Or. Rev. Stat. § 677.095.

[12]Or. Rev. Stat. § 677.190(1).

persons do not ordinarily kill themselves" and has asserted its interest in protecting people from self-harm caused by depression. *United States National Bank v. Underwriters at Lloyd's*, 396 P.2d 765, 770 (Or. 1964).

But the principle that persons who kill themselves almost always do so because of undiagnosed and untreated depression is also true of persons who are terminally ill. There is much evidence in the record to this effect, but it is also conveniently available to this Court in the briefs filed in *Washington v. Glucksberg* and *Vacco v. Quill*, presently awaiting this Court's decision. Because of the extensive material on suicidology presently in the Court's possession, there is little need educate the Court on this issue. A few examples will suffice.

The American Medical Association and the American Psychiatric Association agree that depression causes suicidal desire in terminally-ill patients — just as it does with non-terminally-ill persons:

> [d]epression is the single factor found to be a significant predictor of the desire for death. [citations omitted] In one study of 44 terminally ill patients, all but one of the eleven with "clinical depressive illness" expressed some wish for death, while none of the remaining 33 expressed such a wish. [citations omitted] In this regard, those with terminal or chronic illness are no different than others who express suicidal wishes. Most who commit suicide suffer from depression or some other diagnosable psychiatric illness, which is generally treatable. . . . [citations omitted].

Brief of the American Medical Association, the American Nurses Association, and the American Psychiatric Association, et al. as Amici Curiae in Support of Petitioners, *Quill v. Glucksberg*, No. 95-1858, at 9.

The American Suicide Foundation likewise agrees that depression causes suicidal desire among the terminally ill, just

as it does among those not terminally ill, so that terminally ill patients need protection from assisted suicide equal to that afforded those not terminally ill:

> No sound scientific or clinical basis exists for distinguishing suicidal patients with terminal conditions from other suicidal patients; treatable, reversible mental disorders, usually of a depressive nature, characterize both. Both groups are ambivalent about the desire to die; both suffer extreme anxiety and cognitive impairments; both have excessive needs for control, most dramatically expressed by controlling the time and place of their death. In both groups depression interferes with their decision-making ability.

Brief of the American Suicide Foundation, Amicus Curiae, Supporting Reversal, *Washington v. Glucksberg*, No. 96-110, at 3.

Oregon refuses to assert its protective interests against self harm and assistance in suicide for persons who are terminally ill, even though both terminally and non-terminally persons seek suicide because of depressive illness and would cease seeking suicide if the depression were diagnosed and treated. This constitutes discrimination on the basis of unscientific stereotypes and misinformation, demonstrating a lack of any rational basis for Measure 16. *Cf. Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432 (1985) (striking down a zoning ordinance excluding groups homes for persons with mental retardation on the basis of unscientific stereotypes of such persons).

Because of Measure 16, a person wishing to kill herself will be presumed to be making a reasonable request if she is terminally ill. There will be no general criminal ban to discourage physicians from helping her kill herself. A physician will be able to assert consent as a defense to what formerly constituted homicide. There will be no forceful intervention to prevent self harm. There will be no involuntary civil commitment for expert

evaluation — on the sole basis that a person has sought to harm herself. And what evaluation there is under Measure 16 will not be by a mental health professional, but by a primary care physician. This ignores the fact agreed upon by the American Medical Association and the American Psychiatric Association, that "most physicians fail to recognize depression, thereby precluding the opportunity for effective treatment. [citations omitted.]" Brief of the American Medical Association, the American Nurses Association, and the American Psychiatric Association, et al. as Amici Curiae in Support of Petitioners, *Quill v. Glucksberg*, No. 95-1858, at 9.

In fact, Patricia Wesley, M.D., a psychiatrist and neurologist teaching in the Department of Psychiatry at Yale, declared in an affidavit made a part of the record of this case that probably only psychiatrists could make the difficult diagnosis of depression in terminally patients (who often have depression-like symptoms, such as sleep and appetite disturbance, as a result of their terminal illness or treatment):

> [I]t is not an easy task to diagnose either psychiatric illness or suicidality, and . . . such tasks are probably beyond the expertise of most non-psychiatric physicians. Nonetheless, [Measure 16] asks just such busy, front-line, untrained physicians to perform this vital screening function. It will inevitably be done poorly, and many whose wish to die is based on psychiatric disturbance will be aided in killing themselves.

Affidavit of Patricia Wesley, M.D. at ¶ 27.

And at the time that the lethal prescription is actually taken — days, weeks, or months later — there is no evaluation by *anyone* under Oregon's state-imposed scheme.

Moreover, the physician assisting in suicide under Measure 16, need only meet a "good faith," subjective standard of care, not the general, objective standard of care required of all other

medical diagnosis and treatment.[13] This lowered *good faith* standard of care applies to the requisite diagnoses of whether a person is terminally ill and whether she is mentally "capable" as well as the provision of the prescription intended to be lethal (but which might actually leave the patient badly damaged and in a coma). The Oregon Supreme Court has rejected a lowered, good faith, standard of care for Oregon citizens, but Measure 16 strips terminally ill patients of the legal protections and the legal redress afforded those not terminally ill. *Rogers v. Meridian Park Hospital*, 307 Or. 612, 772 P.2d 929 (Or. 1989) (en banc) (rejecting good faith standard). They are assigned a badge of inferiority as second-class citizens.

In addition, Measure 16 does not even require the notification of the family of the person seeking assistance in suicide — or even a legally appointed guardian — so that there is no natural defender to intervene and protect the person whom the experts say is most likely suffering from undiagnosed and untreated suicidal depression. Measure 16, § 3.05.

As a result, Janice Elsner stands presently stripped of the protections against self harm and assisted suicide enjoyed by other Oregon residents. She does not have the same standard of medical care and the same legal redress afforded Oregon residents who are not terminally ill if her recurring suicidal depression causes her to seek self-harm.

This puts Janice Elsner at imminent and substantial risk of unwanted death. She is imminently dying from progressive muscular dystrophy. App. 59a. As the trial court found, she has

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[13]Measure 16, § 4.01 (emphasis added): "No person shall be subject to civil or criminal liability or professional disciplinary action for participating in *good faith* compliance with this Act. . . . No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating . . . in *good faith* compliance with this Act."

a history of recurring "clinical depression that result[s] in ambivalence about whether she want[s] to continue living." App. 59a-60a.[14] Her "medical histor[y] indicate[s she is] likely to become depressed and unable to control the timing or severity of that depression." App. 60a. "There is significant evidence in the record that depression is a major cause of suicide and is many times undiagnosed." *Id.* Because of Janice Elsner's recurring bouts with suicidal depression, if Oregon's scheme of state-authorized assisted suicide for terminally-ill persons is permitted to go into effect, she is at imminent and substantial risk of death because Oregon's scheme has inadequate safeguards to protect her.

Not only is this imminent life-and-death peril to Janice Elsner of immense concern in itself, but it also indicates that she has standing. Just as prison inmates need not prove that a fire is imminent to have standing, but may challenge prison conditions solely on the basis of an increased risk of fire, so Janice need not prove that she is about to commit suicide, only that she is at imminent and substantial risk for death because of Measure 16 and factors beyond her control. *DiMarzo v. Cahill*, 575 F.2d 15, 18 (1st Cir. 1978), *cert. denied* 439 U.S. 927 (1978). Moreover, as noted above, she already stands stripped of protections from and presumptions about assisted suicide afforded other Oregon residents simply because she is terminally ill, without any consideration of whether she is about to kill herself or not. She should have her day in court to make her case that Measure 16 has denied her the equal protection of the laws and placed her at imminent and substantial risk for unwanted death.

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[14] *Id.* "[A]mbivalence . . . **1:** simultaneous and contradictory attitudes or feelings (as attraction and repulsion) toward an object, person, or action **2 a:** continual fluctuation (as between one thing and its opposite) **b:** uncertainty as to which approach to follow . . . ." *Webster's Ninth New Collegiate Dictionary* at 77 (1985).

What has been said above is sufficient to demonstrate that the Ninth Circuit decision was erroneous with respect to the standing of Janice Elsner. However, it is important to deal specifically with the holding of the Ninth Circuit as to Janice Elsner's standing.

The trial court devoted an entire, separate opinion to discussing the standing issue, carefully establishing who had standing and why. App. 56a. The Ninth Circuit dismissed the standing of Elsner as too speculative. App. 11a-12a. The appellate court decided that for Janice Elsner to "take her life against her true intent"

> the following chain of events would have to occur: (1) Elsner . . . becomes clinically depressed to the point of being unable to make an informed decision to take her own life . . . ; (2) she makes an oral and written request for life-ending medication . . . ; (3) her attending and consulting physicians, neither of whom are required to be a psychologist or psychiatrist . . . , both misdiagnose her as being capable of making an informed decision . . . ; (4) both of the witnesses to her written request will fail to recognize . . . that she is incapable of making an informed decision . . . ; (5) fifteen days after her initial oral request she will still be suffering from severe clinical depression . . . and will make a renewed request to end her life . . . ; (6) immediately prior to writing a prescription for life-ending medication her attending physician will once again misdiagnose her as having made an informed decision . . . ; and (7) after receiving the life-ending medication she will take her own life against her true wishes.

App. 11a-12a.

While the Ninth Circuit has strung out a seven-link chain to demonstrate its claim that Janice Elsner's standing is "conjectural or hypothetical," instead of "actual and imminent," as the

district court found, seven links are too many for the facts and logic to support.

Link 1 is whether Janice would "become[] clinically depressed to the point of being unable to make an informed decision to take her own life." Janice has a history of recurring bouts with clinical depression, which were found likely to recur by the fact finder and during which she has suicidal desires. App. 59a-60a. Thus, where one need only demonstrate "an individualized showing that there is a very significant probability that the future harm will ensue," Janice easily meets this test, and the first link becomes a given. App. 9a.

The Ninth Circuit erroneously took no notice of this factual finding by the trial court in its standing analysis, which of itself shifts her standing from hypothetical to imminent. The facts (1) that she is not at the moment clinically depressed and ambivalent about suicide and life, but (2) that she has recurring bouts with clinical depression, and (3) that while she is clinically depressed she is incapable of bringing suit, fits her in a standing category akin to the classic category of issues capable of repetition yet evading review that require a unique rule for justice to be done. *Roe v. Wade*, 410 U.S. 113, 125 (1973).[15] In fact, Eric Dutson, a terminally-ill plaintiff with recurring clinical depression has already died while this case was in progress, presenting a classic version of the doctrine. App. 7a & n.1, 59-60a.

Links 3, 4, and 6 actually constitute one link, for all relate to the inability of individuals who are not trained health care experts to make the difficult diagnosis of depression in a person

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[15]Of course, she always stands presently devoid of presumptions about and protections from assisted suicide possessed by non-terminally ill persons and burdened with a lower standard of care if she should even consider assisted suicide with her medical care providers as a result of her recurrent depression.

who is terminally ill. If person who is not a health care professional cannot accurately diagnose psychological and psychiatric illnesses, multiple exposures to the non-experts do not improve on that inability. This link is highly likely, not speculative, because there is considerable evidence in the record that even physicians (not to mention the lay witnesses) regularly miss diagnoses of depression in terminally ill persons.[16] Therefore, this is a given, not a speculative link.

Links 2, 5, and 7 relate to the fact of a suicidal person actually pursuing and implementing assisted suicide without depression having abated in 15 days. As the evidence in the record shows, suicidal depression does not abate in the short span of 15 days, particularly if undiagnosed and untreated, nor less in the 48 hours required between the patient's written request and the writing of the lethal prescription. The trial court reviewed the evidence and found that "[t]he possibility that a judgment impairing disorder will resolve itself within this short time frame is unlikely." App. 38a-39a. Therefore, the idea that a suicidally depressed person would still be seeking suicide in fifteen days is a given, not a speculative link.

As to whether clinically depressed persons with suicidal desires (such as Janice Elsner) actually seek suicide assistance and kill themselves — the other topic of links 2, 5, and 7 — that, too, is a given. Links 2, 5, and 7 are really the same link repeated three times, i.e., do people who want suicide actually pursue it to completion over multiple occasions and multiple

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[16]As noted *supra*, the American Medical Association and the American Psychiatric Association agree that "most physicians fail to recognize depression, thereby precluding the opportunity for effective treatment. [citations omitted]." Brief of the American Medical Association, the American Nurses Association, and the American Psychiatric Association, et al. as Amici Curiae in Support of Petitioners, *Quill v. Glucksberg*, No. 95-1858, at 9. Many such authorities and several affidavits were provided to the trial court, which items will be available for review if certiorari is granted.

obstacles? One could posit 15 obstacles instead of three, but it would not lengthen the logical chain beyond one link, for it all boils down to whether people really pursue and commit suicide. The answer is self-evident or there would be no debate over assisted suicide. People really do this — and they pursue suicide over multiple days and obstacles until they succeed or their depression is diagnosed and treated.

Thus, the seven link chain reduces analytically to the following series of givens and a question:

- given that Janice has recurring bouts of clinical depression, which causes her suicidal desires;
- given that suicidal depression does not abate (especially without diagnosis and treatment) in less than 15 days; and
- given that people who are not mental health professionals cannot diagnose depression in terminally ill persons, so Janice's suicidal depression would likely go undiagnosed and untreated by primary-care physicians if she asked for assistance in killing herself;
- is Janice's recurring suicidal depression serious enough (or will it become serious enough) that she would really commit assisted suicide?

Would Janice seek suicide and assistance in doing so? If she would, she would pursue it through multiple occasions and obstacles, just as others do. But finding out if she would actually reach this stage, to which she is so close, is the very thing which Janice seeks to avoid.

Can it really defeat her claim (that she is at imminent and substantial risk for suicide due to suicidal depression and the easy implementation under Measure 16) for the Ninth Circuit to say "I bet she won't do it," so that she has no standing to challenge the statute? That's what it comes down to. The district court said the risk is too great that she will; the Ninth Circuit said the risk is too small that she will.

But the district court considered her recurring bouts with clinical depression in its analysis, and the Ninth Circuit did not. And the Ninth Circuit rejected her standing claim on the basis of a 7-link chain which really boils down to a series of givens and a question posing an individualized and high probability of risk of unwanted death for Janice Elsner. Her recurring clinical depression indicates a substantial risk that the answer is "yes."

But that is the question Janice wishes to avoid answering definitively because it is her life at stake. It is the reason she brought this suit. Her risk is imminent and substantial enough that she should not have to risk more to have it answered.

The real core of the Ninth Circuit's analysis is evident in its opinion shortly after the "chain" discussion. The Ninth Circuit said that a finding of standing could not be based on "probability merely in terms of quantitative percentages," but the plaintiff must show "an *individualized* showing that there is a very significant probability that the future harm will ensue. . . . We are not convinced that Elsner has made such an individualized showing." App. 9a.

But "a very significant probability" of individualized harm is exactly what Elsner has shown in two ways. First, if Measure 16 goes into effect, she would stand presently stripped of presumptions about and protections from assisted suicide which all non-terminally ill Oregon residents enjoy. No probability is involved. That part already exists.

Second, because she stands stripped of the standard of care and the legal redress afforded non-terminally ill Oregon residents, she is at imminent and substantial risk of death, i.e., "a very significant probability" because of her recurring clinical depression.

Janice Elsner's standing is readily apparent, provided one's view is not blocked by excess manufactured chain links. It is "actual and imminent," not "conjectural and hypothetical."

In sum, Janice Elsner's recurring suicidal depression distinguishes her from the possible choke-hold victim upon which the Ninth Circuit relied to deny her standing. App. 13a. She fits exactly the "systematic pattern repetition" that the Ninth Circuit said gives standing. App. 14a. The Ninth Circuit's notion that Elsner's chance of dying under Measure 16 is so speculative as to be "as applicable to every individual in the State of Oregon" cannot be taken seriously. App. 14a.

Janice Elsner's standing was well established in the district court's opinion and has been expanded upon here. In addition, several cases further demonstrate that Janice's present challenge is well within the mainstream of conventional standing law because Oregon has stigmatized the class of terminally-ill persons on the basis of archaic, stereotypical, and unscientific notions about why persons seek suicide.

In a unanimous opinion in *Heckler v. Mathews*, 465 U.S. 728 (1984), this Court acknowledged that "discrimination itself, by perpetuating 'archaic and stereotypic notions' or by stigmatizing members of the disfavored groups as 'innately inferior' and therefore as less worthy . . . can cause serious noneconomic injuries to those persons who are personally denied equal treatment solely because of their membership in the disfavored group." 465 U.S. at 739-40.

In a subsequent opinion, this Court explained that such "stigmatic injury" is cognizable for purposes of standing (i.e., it is "distinct and palpable" and "individualized") if the claimant is "personally subject to discriminatory treatment." *Allen v. Wright*, 468 U.S. 737, 757 n.22 (1984).

In *Northeastern Florida Contractors v. Jacksonville*, ___ U.S. ___, 113 S. Ct. 2297 (1993), this Court held that "an allegation that some discriminatory classification prevented the plaintiff from competing on an equal footing in its quest for a benefit" stated an "injury in fact" sufficient to establish standing. 113 S. Ct. at 2304. According to the Court,

> When the government erects a barrier that makes it more difficult for members of one group to obtain a benefit than it is for members of another group, a member of the former group seeking to challenge the barrier need not allege that he would have obtained the benefit but for the barrier in order to establish standing. The "injury in fact" in an equal protection case of this variety is the denial of equal treatment resulting from the imposition of the barrier, not the ultimate inability to obtain the benefit. . . . And in the context of a challenge to a set-aside program, the "injury in fact" is the inability to compete on an equal footing in the bidding process, not the loss of a contract.

113 S. Ct. at 2303. The Court went on to observe that

> It follows from the definition of "injury in fact" that petitioner has sufficiently alleged both that the city's ordinance is the "cause" of its injury and that a judicial decree directing the city to discontinue its program would "redress" the injury.

113 S. Ct. 2303 n. 5. Thus, all the elements of standing would be satisfied in such a case.

In the present case, persons with terminal conditions as defined by Measure 16 have standing to challenge the Act because they are personally subjected to discrimination solely because of their terminal condition. Measure 16 places "'them in a position of . . . inequality *vis-a-vis*'" similarly situated non-terminally-ill individuals with respect to their interest in receiving the benefits of the suicide protections of other Oregon laws. *Heckler v. Mathews*, 465 U.S. at 738 n.4 (quoting *Baker v. Carr*, 369 U.S. 186, 207 (1962). As a direct result of Measure 16, terminally-ill persons will not be provided the same levels of protection against suicide and suicide assistance otherwise provided to all other Oregon citizens. These protections include the deterrent effect created by the criminal

ban on assisting suicide and the stringent standard of care imposed generally on physicians. Moreover, the disparity in levels of protection will directly perpetuate the stigmatizing belief that terminally-ill persons are less worthy of protection, and directly expose them to the increased risk of depression-induced suicide.

Just as the claim raised in *Northeastern Florida Contractors* sufficiently alleged an injury in fact irrespective of whether the plaintiffs would ever experience an actual loss of the benefit of the city contract, the claim raised by terminally-ill persons at bar states an injury in fact irrespective of whether they will ever take their lives by suicide against their true intent. The essence of their injury lies in the unequal treatment that denies them the same benefits of the homicide code and civil protections provided to non-terminally-ill individuals. This injury will be inflicted the moment that Measure 16 becomes law. Thus, the district court was correct in finding that "Measure 16 implements a significantly lesser standard of care on physicians" and that "[t]his, itself, would confer standing on these plaintiffs." App. 61a.

Several additional cases provide helpful precedent. In *Neighborhood Action Coalition v. Canton*, 882 F.2d 1202 (6th Cir. 1989), the court found standing (under Title VI, which requires at a minimum Article III standing) by parties who

> allege that the City, as a result of a discriminatory animus, provides municipal services and federal funds to a racially identifiable neighborhood in a substantially inferior quality and quantity than the services provided to other areas of Canton. As a result of such actions, appellants claim that they have been injured by experiencing *little or no police response to their calls* . . . . Such injuries, if proven, are personal injuries . . . , are arguably traceable to the City's alleged racial policy, and could be addressed by a judicial order enjoining any

> racially disparate . . . providing of services. Therefore, the appellants have standing to sue in their own right.

882 F. 2d at 1017 (emphasis added). Similarly, Measure 16 directs state authorities to withhold from terminally-ill persons the protections that they provide to non-terminally-ill persons. *See also City of Davis v. Coleman*, 521 F.2d 661, 671 (9th Cir. 1975) (As failure to prepare an environmental impact statement was an injury in fact because it created "a risk that serious environmental impacts will be overlooked," so Measure 16's inferior suicide prevention services for terminally-ill persons increase the risk that suicidal depression will be overlooked.); *Smith v. City of Cleveland Heights*, 760 F.2d 720, 722-24 (6th Cir. 1985) (As a black resident not personally steered away from living in the city by city policy had standing to challenge the city steering policy because it stigmatized him, so terminally-ill persons have standing to challenge Measure 16 for stigmatizing them with second-class standards, even though Measure 16 is ostensibly directed towards persons with terminal conditions who truly desire to end their lives.).

III. Dr. Gary Lee and the other health care providers are entitled to their day in court.

The Ninth Circuit decided that none of the health care providers had standing. In doing so, the panel overlooked or ignored key matters.

A. *In deciding that the health care providers have no standing, the Ninth Circuit overlooked criminal and malpractice liability for noncompliance with Measure 16.*

The Ninth Circuit held that the health care plaintiffs "lack standing to bring this [forced participation] claim because Measure 16 does not provide for any penalty, criminal or otherwise, for violations of the challenged provisions." App. 18a. In so doing, the panel overlooked the fact that the health

care plaintiffs would be subject to malpractice liability, Or. Rev. Stat. § 677.095 (objective duty of care imposed), and, under Measure 16, to criminal liability. Measure 16 provides:

> The penalties in ORS 127.800 to 127.897 [Measure 16] do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of ORS 127.800 to 127.897.

§ 4.02(4); Or. Rev. Stat. § 127.890(4).

Measure 16 thus specifically contemplates criminal liability for conduct inconsistent with it, even if the Measure itself neither contains a specific penalty for, nor specifically classifies, such conduct.

Moreover, Or. Rev. Stat. § 161.555(3) provides:

> An offense defined by a statute of this state, but without specification as to its classification or as to the penalty authorized upon conviction, shall be considered a Class A misdemeanor.

A Class A misdemeanor may be punished by up to one year in prison, Or. Rev. Stat. § 161.615(1), and/or up to a $5,000 fine. Or. Rev. Stat. § 161.635(a).[17]

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[17]A possible objection needs to be dealt with in advance. Oregon law provides that "[a]n offense is conduct for which a sentence to a term of imprisonment or a fine is provided by any law of this state or by any law or ordinance or a political subdivision of this state. An offense is either a crime or a violation or an infraction." Or. Rev. Stat. § 161.505. Thus, it might be argued that since conduct by health care providers inconsistent with Measure 16 is not specifically penalized, it is not an "offense" -- and therefore does not fall within the purview of Or. Rev. Stat. § 161.555(3), which employs the word "offense" as its operative term. Such an argument fails, however, both because it is circular and because it would render Or. Rev. Stat. § 161.155(3) meaningless: the provisions of Or. Rev. Stat. § 161.155(3) were specifically included in Oregon law to provide for penalties for conduct not otherwise penalized by imprisonment or fine under Oregon law.

The Ninth Circuit erred because, even apart from medical malpractice liability, it overlooked the fact that the health care plaintiffs would be subject to criminal liability for failure to conform to the requirements of Measure 16. The panel determined that such "an asserted injury would probably be sufficiently 'imminent' for purposes of standing," citing case law that says one need not "risk arrest or prosecution in order to have standing to challenge the constitutionality of a criminal statute." App. 19a (citation omitted). Under the threat of criminal prosecution for failure to comply with Measure 16, the health care providers have standing.

B. ***In deciding the case of health care providers is not ripe, the Ninth Circuit has overlooked criminal and malpractice liability for noncompliance with Measure 16.***

With respect to the health care plaintiffs, the same risk of criminal and malpractice liability mentioned in the preceding section was also overlooked by the panel when it determined that the plaintiffs' claim was not ripe because they faced, "at worst, . . . a civil enforcement action." App. 19a.

C. ***Because the terminally ill patients have standing, the health care provider plaintiffs ought to be able to assert jus tertii standing for their terminally ill patients with a history of depression.***

If, as argued, persons such as Elsner have standing, then the health care providers ought to be able to assert the interests of their patients suffering the same asserted injury as Elsner. App. 14a-15a.

D. ***In deciding that the health care provider plaintiffs have no standing because Measure 16 itself did not require informed consent dialogues, the panel overlooked the fact that the duty, regardless of its source, created an imminent, concrete, and particularized injury.***

The panel concluded that one reason the health care provider plaintiffs would not have standing is because their duty to advise patients of the Measure 16 option in informed consent dialogues (which would violate religious liberty rights) arises under existing Oregon statutes (prescribing informed consent), not Measure 16. App. 17a n.6. The panel has ignored the fact that if Measure 16 did not exist there would be no problem, but because it exists these plaintiffs have an imminent, concrete, and particularized injury, i.e., the moment Measure 16 goes into effect they must provide information to patients about assisted suicide in violation of their religious liberty rights. The panel overlooked these facts when it stated that "[b]ecause this challenge is directed at the informed consent requirements of state and federal law, and does not go to the validity of Measure 16 itself, we do not consider this claim." *Id.* The panel has confused a cause of action with the imminent injury which gives standing. The plaintiffs suffer an imminent injury because of Measure 16, which gives them standing even though Measure 16 does not itself require the informed consent.

E. *In opining that plaintiffs probably would not meet the causation and redressability elements of standing, the Ninth Circuit misapprehended the fact that both clearly exist.*

The panel overlooked the presence of causation and redressability, stating its doubt that these necessary elements of standing also existed. App. 15a-16a & n.3. For example, Elsner has several injuries from an unenjoined Measure 16, including a lowered standard of care. This injury would be caused by these officials ignoring the unconstitutional discrimination of Measure 16 and implementing Measure 16 by failing to enforce the existing criminal ban and professional disciplinary ban on assisted suicide. Similarly, this problem would be redressed by an injunction, as the district court's injunction has redressed it to date. This is true of all the petitioners before this Court.

CONCLUSION

The question of who has standing to challenge a regime of assisted suicide with lower standards of care imposed on terminally-ill persons is one of immense public importance. If the Ninth Circuit decision stands, dying persons troubled with recurring suicidal desires, such as Janice Elsner, will be deprived of the assurance that their lives are as valued and protected as those not terminally ill. They will be at actual and imminent risk for unwanted death. They will be required to remain in a second-class citizen classification based on unscientific stereotypes and will remain stripped of protections afforded other citizens. Janice should get her day in court to challenge these injustices.

If the Ninth Circuit panel's decision stands Dr. Gary Lee, Dr. William Petty, Sister Geraldine Bernards, Fritz Beck, June Beck, and two residential care facilities will be forced into instant accommodation of, participation in, and association with an assisted suicide scheme which they oppose on grounds of conscience. For those with religious objections, this will violate their right to free exercise of religion. These health care providers should get their day in court to protect their rights.

The Ninth Circuit panel's analysis is flawed in foundation and superstructure. This petition should be granted.

Respectfully submitted,

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May 1997

APPENDIX

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FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

GARY LEE, M.D. individually and on behalf of his patients; WILLIAM PETTY, M.D., individually and on behalf of his patients; ERIC DUTSON, individually and as co-representative of a class of persons who have the disability of a terminal disease even with medical treatment; JANICE ELSNER, individually and as co-representative of a class of persons who have the disability of a terminal disease even with medical treatment; CLAUDINE STOTLER, individually and as a representative of a sub-class of person who have the disability of a terminal disease even with medical treatment and who are being, or will be treated at the Oregon Health Sciences University Hospital; JEFFREY M. WEINKAUF, individually and as a representative of a class of Oregon patients who have a possibly terminal disease absent medical treatment; FRITZ BECK; JUNE BECK; THE WILLOWS HOME, INC.; SISTER GERALDINE BERNARDS, individually and as Administrator of Maryville Nursing Home, Inc.; and MARYVILLE NURSING HOME, INC.,

Plaintiffs-Appellees-Cross-Appellants

v.

Nos. 95-35804
95-35805
95-35854
95-35948
95-35949

D.C. No.
CV-94-06467-MRH

ORDER AMENDING OPINION AND AMENDED OPINION

STATE OF OREGON; DOUGLAS F. HARCLEROAD, in his official capacity as the District Attorney for Lane County, Oregon, and as a representative of the class of all district attorneys in the State of Oregon; JOHN KITZHABER, in his official capacity as Governor of Oregon; TERRY L. CONNOR, D.O., in his official capacity as Chairman of the Oregon Board of Medical Examiners; EDWARD A. HEUSCH, D.O., in his official capacity as Vice-chairman of the Oregon Board of Medical Examiners; CATHERINE M. NATER, in her official capacity as Secretary of the Oregon Board of Medical Examiners; JOHN W. GRIGSBY, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; SARAH S. HENDRICKSON, M.D., in her official capacity as a member of the Oregon Board of Medical Examiners; GEORGE A. PORTER, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; JAMES H. SAMPSON, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; ROSEMARY C. LEE SELINGER, M.D., in her official capacity as a member of the Oregon Board of Medical Examiners; FRED R. STARK, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; MARALYN E. TURNER, in her official

capacity as a member of the Oregon Board of Medical Examiners; J. BRUCE WILLIAMS, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; PETER KOHLER, in his official capacity as the President of the Oregon Health Sciences University; LEE SWANSON, JR., HERBERT ASCHKENASY, ROBERT L.R. BAILEY, DIANE CHRISTOPHER, BOBBY LEE, WALTER R. MILLER, ESTHER PUENTES, GEORGE E. RICHARDSON, JR., RONDA L. TROTMAN REESE, JIM WILLIS, and JANICE J. WILSON, in their official capacities as members of the Oregon State Board of Higher Education; and OREGON HEALTH SCIENCES UNIVERSITY HOSPITAL,

Defendants-Appellants-Cross-Appellees,

and

PETER GOODWIN; BARBARA COOMBS LEE; ELVEN SINNARD; MICHAEL VERNON; TED LEVIN; and TIM SCHUCK,

Intervenors-Appellees-Cross-Appellees.

Appeals from the United States District Court
for the District of Oregon
Michael R. Hogan, District Judge, Presiding

Argued and Submitted
July 9, 1996—Portland, Oregon

Filed February 27, 1997
Amended March 21, 1997
Amended April 16, 1997

Before: Alfred T. Goodwin and Melvin Brunetti, Circuit Judges, and Samuel P. King,* District Judge.

Opinion by Judge Brunetti

[summary omitted; not an official part of decision]

COUNSEL

Thomas O. Alderman, Eugene, Oregon; James Bopp, Jr., Richard E. Coleson, Bopp, Coleson and Bostrom, Terre, Haute, Indiana, for the plaintiffs-appellees-cross-appellants.

Eli Stutsman, Portland, Oregon; Charles F. Hinkle, Stoel, Rives, Boley, Jones & Grey, Portland, Oregon; Thomas M. Christ, ACLU Foundation of Oregon, Inc., Portland, Oregon, for the intervenors-appellees-cross- appellees.

Thomas A. Balmer, Deputy Attorney General, Salem, Oregon for the defendants-appellants-cross-appellees.

ORDER

The opinion amended March 21, 1997, is amended as follows:

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*Hon. Samuel P. King, Senior United States District Judge for the District of Hawaii, sitting by designation.

Slip Opinion page 3099, in the first paragraph of "A. The Proceedings" the first sentence is deleted. The following sentence is inserted in its place: "On November 8, 1994, through the initiative power reserved them under the Oregon Constitution, Oregon voters approved Measure 16, the Oregon Death With Dignity Act ("Measure 16" or "the Act")."

OPINION

BRUNETTI, Circuit Judge:

The plaintiffs in this case are doctors, patients, and residential care facilities challenging the facial validity of the State of Oregon's Death With Dignity Act. Plaintiffs contend the Act violates the First and Fourteenth Amendments to the United States Constitution, as well as several federal statutes. The district court found the Act to violate the Equal Protection Clause and permanently enjoined its enforcement. Because the federal courts do not have jurisdiction to entertain Plaintiffs' claims, we vacate and remand with instructions to dismiss Plaintiffs' complaint.

BACKGROUND

A. The Proceedings

On November 8, 1994, through the initiative power reserved them under the Oregon Constitution, Oregon voters approved Measure 16, the Oregon Death With Dignity Act ("Measure 16" or "the Act"). Measure 16, reprinted in full as an Appendix to this opinion, establishes a statutory framework within which a competent terminally-ill adult may legally request a prescription for medication "for the purpose of ending his or her life in a humane and dignified manner." Measure 16, § 2.01. Fifteen

days before the Act was to take effect, on November 23, 1994, Plaintiffs filed a class action complaint alleging the Act violated their equal protection and due process rights under the Fourteenth Amendment, their free exercise of religion and freedom of association rights under the First Amendment, and their statutory rights under the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101 *et seq.*, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 791 *et seq.*, and the Religious Freedom Restoration Act of 1993, 42 U.S.C. §§ 2000bb *et seq.*

After granting Plaintiffs preliminary injunctive relief preventing the Act from taking effect, *Lee v. State of Oregon,* 869 F.Supp. 1491 (D.Or. 1994) (order granting preliminary injunction), the district court granted summary judgment for Plaintiffs on their equal protection claim and issued a permanent injunction against the Act's enforcement on August 3, 1995. *Lee v. State of Oregon*, 891 F.Supp. 1439 (D.Or. 1995) (declaratory judgment and permanent injunction); *Lee v. State of Oregon,* 891 F.Supp. 1429 (D.Or. 1995) (equal protection opinion). Essentially, the district court found that the Act violated the Equal Protection Clause because it provided insufficient safeguards to prevent against an incompetent (i.e. depressed) terminally-ill adult from committing suicide, thereby irrationally depriving terminally-ill adults of safeguards against suicide provided to adults who are not terminally ill. The district court did not address Plaintiffs' other claims for relief.

B. The Parties

1. Plaintiffs

In an opinion issued contemporaneously with its equal protection ruling, the district court determined that the only plaintiffs who have standing to assert an equal protection, due

process, Americans with Disabilities Act, or Rehabilitation Act challenge are: Eric Dutson[1] and Janice Elsner, two competent terminally-ill adults who have suffered from bouts of depression in the past, and Maryville Nursing Home and Willows Home, two residential care facilities. *Lee v. State of Oregon*, 891 F.Supp. 1421 (D.Or. 1995) (standing opinion). In a cross-appeal, Drs. Gary Lee and William Petty challenge the district court's finding that they did not have standing to assert equal protection and due process challenges on behalf of their patients. [Red 50-55; ER 91.] Additionally, Plaintiffs cross-appeal the district court's denial of their motion to certify a class consisting of all individuals in the State of Oregon who have a "terminal disease" as defined in Measure 16. *See* Measure 16, § 1.01(12) (defining "terminal disease" as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months").

As for Plaintiffs' First Amendment and Religious Freedom Restoration Act challenges, the district court determined that Dr. Petty, Maryville Nursing Home, Sister Geraldine Bernards as the administrator of Maryville Nursing Home, Willows Home, and Fritz and June Beck as the owners of Willows Home, all had standing to assert these claims.

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[1]Mr. Dutson died on July 2, 1995, a month before the district court entered judgment for plaintiffs and issued a permanent injunction. Apparently, however, Plaintiffs' counsel did not inform the district court of Dutson's death until August 8, 1995, five days after the entry of judgment. [See CR 193 (notification of Dutson death); CR 191, ER 98-99 (declaratory judgment and permanent injunction).]

2. Defendants

The district court determined that the only properly named defendants were: Douglas F. Harcleroad, District Attorney for Lane County, Oregon, and all eleven members of the Oregon State Board of Medical Examiners. The state of Oregon and the attorney general and governor of Oregon were dismissed on Eleventh Amendment immunity grounds. Additionally, the district court determined that several Oregon citizens could properly intervene as defendants pursuant to Federal Rule of Civil Procedure 24. Defendants appeal the district court's grant of summary judgment on Plaintiffs' equal protection claim and the denial of Defendants' motion for summary judgment on all of Plaintiffs' claims.

DISCUSSION

The judicial power of the United States, both provided and limited by Article III of the Constitution, "is not an unconditioned authority to determine the constitutionality of legislative or executive acts." *Valley Forge Christian College v. Americans United for Separation of Church and State Inc.*, 454 U.S. 464, 471 (1982). Rather, "[t]he power to declare the rights of individuals and to measure the authority of governments . . . 'is legitimate only in the last resort, and as a necessity in the determination of real, earnest and vital controversy.' " *Id.* (quoting *Chicago & Grand Trunk R. Co. v. Wellman*, 143 U.S. 339, 345 (1892)). In order to ensure that a federal court's Article III power has been properly invoked, the courts have developed several doctrines, including standing, mootness, and ripeness, each of which imposes a different requirement on the substance of a plaintiff's claim. *See Allen v. Wright*, 468 U.S. 737, 750 (1984). We are particularly concerned in this case with standing and ripeness.

The standing doctrine addresses the question of "whether the litigant is entitled to have the court decide the merits of the dispute." *Warth v. Seldin*, 422 U.S. 490, 498 (1975). At its core, the standing requirement has three "irreducible constitutional[ly] minimum " elements. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992).

> First, the plaintiff must have suffered an "injury in fact" — an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical. Second, there must be a causal connection between the injury and the conduct complained of — the injury has to be fairly traceable to the challenged action of the defendant, and not the result of the independent action of some third party not before the court. Third, it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision.

Id. at 560-61 (citations, internal quotations and footnote omitted).

While standing is primarily concerned with *who* is a proper party to litigate a particular matter, ripeness addresses *when* that litigation may occur. *See* Erwin Chemerinsky, *Federal Jurisdiction* § 2.4, at 98-99 (1989). The "basic rationale" of the ripeness doctrine is "to prevent the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements." *Abbott Laboratories v. Gardner*, 387 U.S. 136, 148 (1967). When a party is challenging the validity of a statute or regulation, the ripeness doctrine can be specifically understood "as involving the question of when may a party seek preenforcement review." Chemerinsky, § 2.4 at 100 (emphasis omitted). Whether a claim is ripe depends on "the fitness of the issues for judicial decision and the hardship to the

parties of withholding court consideration." *Abbott Laboratories*, 387 U.S. at 149; *see Freedom to Travel Campaign v. Newcomb*, 82 F.3d 1431, 1434 (9th Cir. 1996). Both standing and ripeness are jurisdictional issues reviewed *de novo*. *Wedges/Ledges of California, Inc. v. City of Phoenix*, 24 F.3d 56, 61 (9th Cir. 1994); *Southern Pac. Transp. Co. v. City of Los Angeles*, 922 F.2d 498, 502 (9th Cir. 1990), *cert. denied*, 502 U.S. 943 (1991).

A. Equal Protection, Due Process, Americans with Disabilities Act, and Rehabilitation Act Claims

The one remaining individual plaintiff held to have standing to assert Plaintiffs' equal protection, due process, Americans with Disabilities Act, and Rehabilitation Act claims is Janice Elsner. She has a progressive form of muscular dystrophy and has already lived longer than doctors expected. Although she has not been given a prognosis of less than six months to live, for purposes of analysis we will assume that she has a terminal disease within the meaning of Measure 16. In the past, Elsner has suffered clinical depression that resulted in ambivalence about whether she wanted to continue living. The threatened injury asserted by Elsner is the possibility that, utilizing the procedures established by Measure 16, she will take her own life against her true intent. For this injury to manifest itself, the following chain of events would have to occur: (1) Elsner (a) becomes clinically depressed to the point of being unable to make an informed decision to take her own life, or (b) is unduly influenced by a third party to take her own life; (2) she makes an oral and a written request for life-ending medication, *see* Measure 16, §§ 2.02, 3.06; (3) her attending and consulting physicians, neither of which are required to be a psychologist or psychiatrist under the Act, both misdiagnose her as being capable of making an informed decision, *see id.* §§ 3.01-3.04;

(4) both of the witnesses to her written request will fail to recognize (either intentionally or unintentionally) that she is incapable of making an informed decision or has been subject to undue influence, *see id.* § 2.02; (5) fifteen days after her initial oral request she will still be suffering from severe clinical depression or undue influence and will make a renewed request to end her life, *see id.* § 3.08; (6) immediately prior to writing a prescription for life-ending medication her attending physician will once again misdiagnose her as having made an informed decision, *see id.* § 3.04; and (7) after receiving the life-ending medication she will take her own life against her true wishes.

Despite this chain of speculative contingencies, the district court found the threatened injury to be "actual and imminent" rather than "conjectural or hypothetical." As argued by Plaintiffs-Appellees, standing exists

> because [t]he empirical facts reveal that the risk of harm to terminally ill patients is far from speculative: (1) persons with a terminal disease are at a greatly increased risk for depression; (2) depression carries with it a serious risk of becoming suicidal; and (3) primary care physicians regularly miss suicidal depression in their own patients.

Appellees' Brief, at 49.

Even if the record before the district court could support these "empirical facts," they are insufficient to confer standing on Elsner. First, as a matter of quantitative probability, the "facts" only indicate that terminally-ill adults are at a greater risk of depression than those who are not terminally ill, and do not demonstrate that a significant number of terminally-ill adults have depression severe enough to prevent them from making an informed decision. More importantly, we have previously stated

that our analysis on this issue "cannot be reduced to considering probability merely in terms of quantitative percentages," *Nelsen v. King County*, 895 F.2d 1248, 1250 (9th Cir. 1990), but must instead focus qualitatively on whether the plaintiff has made "an *individualized* showing that there is 'a very significant possibility' that the future harm will ensue." *Id.* (emphasis added) (quoting *Sample v. Johnson*, 771 F.2d 1335, 1343 (9th Cir. 1985)). We are convinced that Elsner has not made such an individualized showing.

Several precedents support our conclusion. In *City of Los Angeles v. Lyons*, 461 U.S. 95 (1983), the Supreme Court considered whether an individual who had been subjected to an unconstitutional chokehold by the Los Angeles police had standing to seek injunctive relief preventing the police from using the chokehold in the future. Despite the allegation that the Los Angeles police routinely applied chokeholds in situations when they were not threatened by the use of deadly force, *id.* at 105, and the acknowledgment of a possibility that someone in Los Angeles would be killed by the application of an unconstitutional chokehold, *id.* at 108, the Court found no standing because it was "no more than speculation to assert . . . that Lyons *himself* would again be subject to an unconstitutional chokehold. *Id.* (emphasis added).

Likewise, in *O'Shea v. Littleton*, 414 U.S. 488 (1974), the Court found a lack of standing when the plaintiffs would only be subjected to the alleged discriminatory and otherwise unconstitutional administration of criminal justice within a particular county if they proceeded to violate a law and were charged, held to answer, and tried in the county. The Court reasoned that "attempting to anticipate whether and when these respondents will be charged with crime and will be made to appear before either petitioner takes us into the area of specula

tion and conjecture," *id.* at 497, and held that such speculation and conjecture were insufficient to confer standing.

In our own circuit, we "have repeatedly found a lack of standing where the litigant's claim relies upon a chain of speculative contingencies." *Nelsen*, 895 F.2d at 1252. For example, in *Nelsen*, we held that individuals who had been detained in an alcohol treatment center did not have standing to seek injunctive relief challenging conditions of detention within the center because in order to suffer injury they would have to "remain within [the c]ounty, remain indigent, begin drinking uncontrollably several years after their discharge from the Center . . . commit an alcohol-related offense, be prosecuted for that offense, be convicted, be offered the choice to reenter the Center, make that choice, *and* find that the conditions at the Center were the same as they allegedly were [before]." *Id.* at 1252; *see also Eggar v. City of Livingston*, 40 F.3d 312, 317 (9th Cir. 1994) (claim of standing for injunctive relief against a judge for the unconstitutional denial of the right to counsel held too speculative when the plaintiffs would have to "commit future crimes in the City, be indigent, plead guilty, and be sentenced to jail"), *cert. denied*, ___ U.S. ___, 115 S.Ct. 2566 (1995); *Oregon State Police Officers Ass'n v. Peterson*, 979 F.2d 776, 778 (9th Cir. 1992) (union's claim of standing for injunctive relief against the Supreme Court of Oregon for the unconstitutional denial of attorneys fees in 42 U.S.C. § 1983 cases held too speculative when "a state or local government employer would have to violate both state and federal law; the violation would have to injure a member of the Union; the case would have to be reduced to judgment rather than settled; and the state court would have to rule in the Union's favor on the state issue but not reach the federal question or decide on both state and federal grounds"); Nelsen, 895 F.2d at 1253-54 (collecting cases). *See generally Nelsen*, 895 F.2d at 1254 (concluding that "[i]n those circumstances where we, or the

Supreme Court, have found standing to exist for a threat of future harm, it has consistently been determined that some systematic pattern repetition, or relationship exists").

The district court seemed to base its holding on two rationales — that there was a danger Elsner would only have standing after she was dead or close to death, and that if Elsner did not have standing, nobody would. The chance of Elsner dying according to the scenario presented is so speculative, however, that the first rationale is almost as applicable to every individual in the State of Oregon. Just because the asserted injury is the threat of death does not mean that the plaintiff is relieved from the requirement of asserting some significant possibility of injury. *See Lyons*, 461 U.S. at 108 (acknowledging that someone in the future may be killed by the unconstitutional application of a chokehold, but finding no standing because it was only speculation that the plaintiff would). As for the second rationale, the Supreme Court has held that "[t]he assumption that if respondents have no standing to sue, no one would have standing, is not a reason to find standing." *Valley Forge Christian College*, 454 U.S. at 489 (quoting *Schlesinger v. Reservists Committee to Stop the War*, 418 U.S. 208, 227 (1974)).

Nor would our analysis change if the named residential care facilities and doctors could assert these claims on behalf of their patients. *See Powers v. Ohio*, 499 U.S. 400, 411 (1991) (holding that a litigant may bring an action on behalf of a third party so long as: (1) the litigant has suffered an "injury in fact"; (2) the litigant has a close relation to the third party; and (3) there is some hindrance to the third party's ability to protect his or her own interests). At best, the doctors and residential care facilities would be asserting the interests of unnamed patients

who are no closer to suffering the asserted injury than Elsner.[2] Because these unnamed patients would not have standing to assert their own interests, their doctors and care-givers cannot have standing to assert interests on their behalf.

Lastly, the fact that Plaintiffs filed their complaint as a class action is of no moment. Standing "is a jurisdictional element that must be satisfied prior to class certification." *Nelsen*, 895 F.2d at 1249-50 (quoting *LaDuke v. Nelson*, 762 F.2d 1318, 1325 (9th Cir. 1985)). "If the litigant fails to establish standing, he may not 'seek relief on behalf of himself or any other member of the class.' " *Id.* at 1250 (quoting *O'Shea*, 414 U.S. at 494).

None of the Plaintiffs can assert an "injury in fact" resulting from the alleged equal protection, due process, Americans with Disabilities Act, or Rehabilitation Act violations. While we also doubt that Plaintiffs have met the other two constitutional requirements for standing — that there is a causal connection between the injury and the conduct complained of[3] and that the

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[2]We note that Elsner may not in fact have a "terminal disease" as defined in Measure 16, and may therefore not be able to invoke Measure 16's provisions in the first instance. However, precisely because of the possibility that the named doctors and residential care facilities could assert the interests of their terminally-ill patients, we assume that Elsner does have a "terminal disease" for purposes of the "injury in fact" analysis.

[3]The remaining named defendants are a district attorney responsible for the prosecution of Oregon's ban on assisted suicide and the board responsible for regulating the medical profession in Oregon. Elsner's injury, however, would result not only from the action (or inaction) of these defendants, but also from the independent actions of herself, her treating physician, the consulting physician, the witnesses to her written request, and possibly other individuals asserting undue influence on her decision-making process. It is doubtful, therefore, that the injury asserted by Elsner is "fairly traceable to the challenged action of the defendant, and not the result of the independent

injury will be redressed by a favorable decision[4] — we need not address these concerns. The failure to assert an "injury in fact" requires the dismissal of these claims.[5]

B. First Amendment and RFRA Claims

The district court found that Dr. William Petty, Maryville Nursing Home, Sister Geraldine Bernards as Maryville Nursing Home's administrator, Willows Home, and Fritz and June Beck as the owners of Willows Home all had standing to assert that they will be forced to carry out certain actions under Measure 16 in violation of their rights under the First Amendment and the Religious Freedom Restoration Act. These plaintiffs assert

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action of some third party not before the court." *Lujan*, 504 U.S. at 560.

[4]We express no opinion on the possibility of redress by future litigation. The decision of this court in *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc) is now pending before the Supreme Court, *cert. granted* ___ U.S. ___, 117 S.Ct. 37 (1996), and we need not and do not address any of the substantive questions that may be answered or dealt with in that case.

[5]At oral argument, Plaintiffs also argued that, in the case of terminally-ill patients, Measure 16 reduces the standard of care doctors owe their patients from objective reasonableness to subjective good faith. *Compare* O.R.S. § 677.095 ("A physician . . . has the duty to use that degree of care, skill, and diligence which is used by ordinarily careful physicians . . . in the same or similar circumstances. . . .") *with* Measure 16 § 4.01(1) ("No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this Act."). This reduction, argue Plaintiffs, is itself an injury sufficient to confer standing.

We reject this argument because we find that, even were Plaintiffs correct in their interpretation of Measure 16, the mere reduction in the standard of care owed by doctors to their terminally-ill patients is insufficient to confer standing without an allegation that an individual patient has suffered or will imminently suffer some concrete and particularized injury as a result of the reduction in the standard of care.

two different types of injuries: First, all five of these plaintiffs assert that Measure 16 will force them to participate in the prescription of life-ending medication, either by being required to transfer the medical records of a patient who is seeking life-ending medication to another physician (Measure 16, § 4.01(4)), by being required to advise a patient of the option of Measure 16's procedures (*id.* § 3.01(2)), or (in the case of the residential care facilities) by being required to appoint a witness to a patient's written request for life-ending medication (*id.* § 2.02(4)).[6] Second, the residential care facilities and their administrators assert that Measure 16 will prevent them from excluding physicians who wish to prescribe life-ending medication to the facilities' residents. *See id.* § 4.01(2). These asserted injuries are appropriately analyzed separately.

1. Alleged Forced Participation

Plaintiffs assert that Measure 16 violates their First Amendment and RFRA rights by forcing them to participate in a patient's suicide in three separate ways. Assuming (without deciding) that Measure 16 does in fact require them to perform the asserted acts, their claim suffers from both standing and ripeness defects.

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[6]Plaintiffs also allege that, pursuant to other provisions of state and federal law, *see* 42 U.S.C. § 1395cc(f)(1)(A)(i) (requiring health care organizations to provide written information to patients concerning their "rights under State law . . . to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives"); O.R.S. § 677.097 (describing the procedure required under Oregon law to obtain the informed consent of a patient), they will be unconstitutionally forced to inform patients of the availability of Measure 16's procedures. Because the challenge is directed at the informed consent requirements of state and federal law, and does not go to the validity of Measure 16 iteself, we do not consider this claim.

Plaintiffs lack standing to bring this claim because Measure 16 does not provide for any penalty, criminal or otherwise, for a violation of the challenged provisions. *See* Measure 16 § 4.02 (providing criminal penalties only for forging a request and coercing a patient to make a request for life ending medication). Thus, while an asserted injury would probably be sufficiently "imminent" for purposes of standing, *see Babbitt v. United Farm Workers National Union,* 442 U.S. 289, 298-99 (1979) (holding that a plaintiff does not have to risk arrest or prosecution in order to have standing to challenge the constitutionality of a criminal statute), Plaintiffs have failed to allege a "concrete and particularized" injury in the first instance. *See Lujan*, 504 U.S. at 560 (stating that injury must be "concrete and particularized" *and* "actual or imminent"). Without such an injury, Plaintiffs lack standing.

For the same reason, this claim is not ripe. While the issues may be fit for judicial consideration because they are predominately legal ones that do not depend on a particular factual context, *see Newcomb,* 82 F.3d at 1434 (stating that "[l]egal questions that require little factual development are more likely to be ripe"), this claim is not ripe because Plaintiffs have not identified any hardship that would befall them if their claims were not considered at this time. *See Toilet Goods Ass'n v. Gardner,* 387 U.S. 158, 165 (1967) (dismissing claim on ripeness grounds because noncompliance with the challenged regulation "would at most lead only to a suspension of certification services to the particular party, a determination that can then be promptly challenged through an administrative procedure, which in turn is reviewable by a court") (footnote omitted). Noncompliance with the allegedly offending provisions of Measure 16 would lead, at worst, to a civil enforcement action, at which time the plaintiff doctors and health care organizations could more appropriately challenge the provisions' validity.

2. Alleged Forced Association With Those Who Do Participate

The residential care facilities and their administrators also assert that Measure 16 will prevent them from excluding physicians who wish to prescribe life-ending medication to the facilities' residents, in violation of their rights to freedom of association and freedom of religion. Because these plaintiffs have not alleged that there are in fact any doctors at their facilities who will participate in Measure 16's procedures, there is no "injury in fact" upon which to base standing.

CONCLUSION

The federal courts do not have Article III jurisdiction over Plaintiffs' claims. Accordingly, we vacate the judgment of the district court and remand with instructions to dismiss Plaintiffs' complaint for lack of jurisdiction.

VACATED AND REMANDED.

APPENDIX

THE OREGON DEATH WITH DIGNITY ACT

SECTION 1 GENERAL PROVISIONS

§ 1.01 DEFINITIONS

The following words and phrases, whenever used in this Act, shall have the following meanings:

(1) "Adult" means an individual who is 18 years of age or older.

(2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

(3) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

(4) "Counseling" means a consultation between a state licensed psychiatrist or psychologist and a patient for the purpose of determining whether the patient is suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.

(5) "Health care provider" means a person licensed, certified, or otherwise authorized or permitted by the law of this

State to administer health care in the ordinary course of business or practice of a profession, and includes a health care facility.

(6) "Incapable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, a patient lacks the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available. Capable means not incapable.

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an of the relevant facts and after being fully informed by the attending physician of:

(a) his or her medical diagnosis;

(b) his or her prognosis;

(c) the potential risks associated with taking the medication to be prescribed;

(d) the probable result of taking the medication to be prescribed;

(e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of this Act in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months.

SECTION 2
WRITTEN REQUEST FOR MEDICATION TO END ONE'S LIFE IN A HUMANE AND DIGNIFIED MANNER

§ 2.01 WHO MAY INITIATE A WRITTEN REQUEST FOR MEDICATION

An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with this Act.

§ 2.02 FORM OF THE WRITTEN REQUEST

(1) A valid request for medication under this Act shall be in substantially the form described in Section 6 of this Act, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.

(2) One of the witnesses shall be a person who is not:

(a) A relative of the patient by blood, marriage or adoption;

(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Resources by rule.

SECTION 3
SAFEGUARDS

§ 3.01 ATTENDING PHYSICIAN RESPONSIBILITIES

The attending physician shall:

(1) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;

(2) Inform the patient of:

(a) his or her medical diagnosis;

(b) his or her prognosis;

(c) the potential risks associated with taking the medication to be prescribed;

(d) the probable result of taking the medication to be prescribed;

(e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(3) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;

(4) Refer the patient for counseling if appropriate pursuant to Section 3.03;

(5) Request that the patient notify next of kin;

(6) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15 day waiting period pursuant to Section 3.06;

(7) Verify, immediately prior to writing the prescription for medication under this Act, that the patient is making an informed decision:

(8) Fulfill the medical record documentation requirements of Section 3.09;

(9) Ensure that all appropriate steps are carried out in accordance with this Act prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner.

§ 3.02 CONSULTING PHYSICIAN CONFIRMATION

Before a patient is qualified under this Act, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision.

§ 3.03 COUNSELING REFERRAL

If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, either physician shall refer the patient for counseling. No

medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.

§ 3.04 INFORMED DECISION

No person shall receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision as defined in Section 1.01(7). Immediately prior to writing a prescription for medication under this Act, the attending physician shall verify that the patient is making an informed decision.

§ 3.05 FAMILY NOTIFICATION

The attending physician shall ask the patient to notify next of kin of his or her request for medication pursuant to this Act. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

§ 3.06 WRITTEN AND ORAL REQUESTS

In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician no less than fifteen (15) days after making the initial oral request. At the time the qualified patient makes his or her second oral request, the attending physician shall offer the patient an opportunity to rescind the request.

§ 3.07 RIGHT TO RESCIND REQUEST

A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under this Act may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

§ 3.08 WAITING PERIODS

No less than fifteen (15) days shall elapse between the patient's initial oral request and the writing of a prescription under this Act. No less than 48 hours shall elapse between the patient's written request and the writing of a prescription under this Act.

§ 3.09 MEDICAL RECORD DOCUMENTATION REQUIREMENTS

The following shall be documented or filed in the patient's medical record:

(1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;

(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;

(3) The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;

(4) The consulting physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;

(5) A report of the outcome and determinations made during counseling, if performed;

(6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request pursuant to Section 3.06; and

(7) A note by the attending physician indicating that all requirements under this Act have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

§ 3.10 RESIDENCY REQUIREMENT

Only requests made by Oregon residents, under this Act, shall be granted.

§ 3.11 REPORTING REQUIREMENTS

(1) The Health Division shall annually review a sample of records maintained pursuant to this Act.

(2) The Health Division shall make rules to facilitate the collection of information regarding compliance with this Act. The information collected shall not be a public record and may not be made available for inspection by the public.

(3) The Health Division shall generate and make available to the public an annual statistical report of information collected under Section 3.11(2) of this Act.

§ 3.12 EFFECT ON CONSTRUCTION OF WILLS, CONTRACTS AND STATUTES

(1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid.

(2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner.

§ 3.13 INSURANCE OR ANNUITY POLICIES

The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy.

§ 3.14 CONSTRUCTION OF ACT

Nothing in this Act shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with this Act shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.

SECTION 4
IMMUNITIES AND LIABILITIES

§ 4.01 IMMUNITIES

Except as provided in Section 4.02:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this Act. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with this Act.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of this Act shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this Act, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

§ 4.02 LIABILITIES

(1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death shall be guilty of a Class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony.

(3) Nothing in this Act limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

4) The penalties in this Act do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of this Act.

SECTION 5
SEVERABILITY

§ 5.01 SEVERABILITY

Any section of this Act being held invalid as to any person or circumstance shall not affect the application of-any other section of this Act which can be given full effect without the invalid section or application.

SECTION 6
FORM OF THE REQUEST

§ 6.01 FORM OF THE REQUEST

A request for a medication as authorized by this act shall be in substantially the following form:

REQUEST FOR MEDICATION
TO END MY LIFE IN A HUMANE
AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.

I am suffering from _____, which my attending physician has determined is a terminal disease and which has been medically confined by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed:

_____

Dated:

_____

DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) Is personally known to us or has provided proof of identity;

(b) Signed this request in our presence;

(c) Appears to be of sound mind and not under duress, fraud or undue influence;

(d) Is not a patient for whom either of us is attending physician.

_____

Witness 1/Date

_____

Witness 2/Date

NOTE: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

The Act set forth above (Ballot Measure No. 16) was proposed by initiative petition and was enacted by a vote of 627,980 to 596,018 at the regular general election on November 8, 1994. By proclamation of the Governor dated December 7, 1994, the Act was declared to have received an affirmative majority of the total number of votes cast thereon and to be in full force and effect as provided in section 1, Article IV, Oregon Constitution on December 8, 1994.

[file mark: Aug. 3, 1995]

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

Gary LEE, et al.,	)	
	)	
Plaintiffs,	)	Civil No. 94-6467-HO
	)	
v.	)	DECLARATORY
	)	JUDGMENT AND
STATE OF OREGON, et al.,	)	PERMANENT
	)	INJUNCTION
Defendants.	)	
	)	

The court, having considered the parties' dispositive motions, having granted plaintiffs' motion for summary judgment as to the Equal Protection Clause claim, and having granted certain of defendants' motions for summary judgment as to standing, intervention and immunity, grants plaintiffs Dutson, Elsner, Willows Residential Care Facility, and Maryville Nursing Home a declaratory judgment and permanent injunction against the remaining defendants.

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that:

(1) Oregon's Death With Dignity Act ("Measure 16") violates the Equal Protection Clause of the Fourteenth Amendment of the Constitution of the United States;

(2) Defendants are permanently enjoined from recognizing the constitutionality of Measure 16;

(3) Defendant District Attorney Harcleroad is permanently enjoined from recognizing any exceptions from criminal law created by Oregon Ballot Measure 16 in the exercise of his criminal enforcement duties;

(4) Defendant members of the State Board of Medical Examiners are permanently enjoined from recognizing any exceptions from law or regulation governing physician's conduct created by Oregon Ballot Measure 16 in the exercise of their duties involving licensure, quality control, continuing education, and discipline of physicians;

Nominal security is set in this matter in the amount of $1.00, to be posted in the form of cash or bond with the clerk of this court.

This injunction is binding upon the defendants, their agents, servants, employees, and attorneys, and upon those persons in active concert or participation with them who receive actual notice of this order by personal service or otherwise.

IT IS SO ORDERED.

DATED THIS 3rd day of August, 1995.

/s/ Michael R. Hogan
UNITED STATES DISTRICT JUDGE

[file mark: Aug. 3, 1995]

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

Gary LEE, et. al.,	)	
	)	
Plaintiffs,	)	Civil No. 94-6467-HO
	)	
v.	)	OPINION
	)	(Equal Protection)
STATE OF OREGON,	)	
	)	
Defendants.	)	
	)	

In November 1994, Oregon voters narrowly approved a ballot initiative that allows a terminally ill adult to obtain a doctor's prescription for a fatal drug dosage for the express purpose of ending their life. The Oregon Death With Dignity Act ("Measure 16")[1] is the first of its kind in this country, and it is an understatement to say that the Act invokes profound questions of constitutional dimension. Plaintiffs claim that Measure 16 violates the Equal Protection and Due Process Clauses of the Fourteenth Amendment of the Constitution (Counts One, Two, and Four), statutory and First Amendment

[1]The term "assisted suicide" shall be used throughout this opinion as a term of art and general description of Measure 16 subject matter.

rights of freedom to exercise religion and to associate (Count Five), and the American with Disabilities Act ("ADA") (Count Three). (Third Amended Complaint, # 170).

Under the United States Constitution and the system it establishes, the resolution of an issue such as the legality of physician assisted suicide is, in the first instance, left to the democratic processes of a state. Although the complexity of life and death decisions may call for legislative participation, the judiciary cannot simply defer to state legislative processes when presented with a law which may not provide adequate constitutional guidance and protection to citizens. A state-sanctioned option designed to hasten death induces hesitation and reflection. It is the court's duty to carefully and conscientiously address any constitutional issues. Compassion, justice, prudence, and fortitude are all ingredients in the law, but the guiding "compass is the Constitution of the United States." *Compassion in Dying v. State of Washington,* 49 F.3d 586, 594 (9th Cir. 1995).

Requiring that issues relating to physician assisted suicide be addressed within constitutional limits does not frustrate the authority of citizens to govern themselves. To the contrary, it ensures the integrity of the voting process by recognizing the deeply imbedded constitutional principle that certain fundamental rights may not be dispensed with by a majority vote.

I. EQUAL PROTECTION CLAUSE

Plaintiffs allege that the provisions of Measure 16 violate the Equal Protection Clause of the Fourteenth Amendment to the Constitution. They argue that Measure 16's classification or

coverage to the "terminally ill" is not rationally related to a legitimate state interest.[2]

The Fourteenth Amendment commands, in part, that no state shall "deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, § 1. The Equal Protection Clause does not forbid differentiating between classes of persons. Rather, it simply prohibits the states from treating persons differently who are, in all relevant respects, alike. *Nordlinger v. Hahn*, 505 U.S. 1, 10, 112 S.Ct. 2326, 2331, 120 L.Ed.2d 1 (1992) (citation omitted).

Legislation is presumed valid if a classification drawn by a statute is rationally related to a legitimate state interest. *Schweiker v. Wilson*, 450 U.S. 221 (1981). The Equal Protection Clause allows wide latitude in social legislation. *United States Railroad Retirement Board v. Fritz*, 449 U.S. 166, 174, 101 S.Ct. 453, 459, 66 L.Ed.2d 368 (1980). A legitimate state interest must encompass the interests of the members of the community at large, as well as disadvantaged and favored classes. Legislative decisionmakers are not required to articulate the rationale supporting a classification, and the state is not required to produce evidence or empirical data to support it. *Heller v. Doe by Doe*, 509 U.S. 312, —, 113 S.Ct. 2637, 125 L.Ed.2d 257 (1993). It is irrelevant that the voters rather than a legislative body enacted the statute for purposes of this constitutional review. *Citizens Against Rent Control v. City of Berkeley*, 454 U.S. 290, 293, 295, 102 S.Ct. 434, 436, 437, 70 L.Ed.2d 492 (1981). Plaintiffs have the burden of proving any violation of the Equal Protection Clause. *Burlington Northern*

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[2]The court has, therefore, limited its analysis and is not deciding whether a heightened or strict scrutiny test may apply if Measure 16 implicates a fundamental liberty interest.

Railroad Co. v. Department of Public Service Regulation, 763 F.2d 1106, 1113 (9th Cir.1985).

A classification "must be upheld against an equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification." *F.C.C. v. Beach Communications, Inc.*, 508 U.S. 307, ----, 113 S.Ct. 2096, 2100, 124 L.Ed.2d 211 (1993). A classification rationally furthers a state interest when there is some fit between the disparate treatment and the legislative purpose. *See Katzenbach v. Morgan*, 384 U.S. 641, 657, 86 S.Ct. 1717, 1727, 16 L.Ed.2d 828 (1966). When faced with doubts as to the constitutionality of a statute, the court must first determine whether it is fairly possible to interpret the statute in a manner that renders it valid. *Communications Workers of America v. Beck*, 487 U.S. 735, 762, 108 S.Ct. 2641, 2657, 101 L.Ed.2d 634 (1988). However, "statutory construction may not be pressed to the point of disingenuous evasion." *Id.* at 762, 108 S.Ct. at 2657 (quotation omitted).

A state is free to create a classification scheme so long as it does not invidiously discriminate. *City of Cleburne, Tex. v. Cleburne Living Center*, 473 U.S. 432, 105 S.Ct. 3249, 87 L.Ed.2d 313 (1985) (labeled "irrational prejudice"); *Lehnhausen v. Lake Shore Auto Parts Co.*, 410 U.S. 356, 93 S.Ct. 1001, 35 L.Ed.2d 351 (1973); *Jackson Water Works v. Public Utilities Com'n*, 793 F.2d 1090, 1093 (9th Cir.1986). The state may not rely on a classification whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational. *Zobel v. Williams*, 457 U.S. 55, 102 S.Ct. 2309, 72 L.Ed.2d 672 (1982); *United States Dept. of Agriculture v. Moreno*, 413 U.S. 528, 93 S.Ct. 2821, 37 L.Ed.2d 782 (1973); *Nordlinger v. Hahn*, 505 U.S. at 18, 112 S.Ct. at 2336. However, the underinclusiveness or overinclusiveness of a classification may be so severe that it

cannot be said that the legislative distinction "rationally furthers" the state interest. *Burlington Northern Railroad Co. v. Ford*, 504 U.S. 648, 653-54, 112 S.Ct. 2184, 2188, 119 L.Ed.2d 432 (1992).

Equal protection analysis is used to determine whether a classification is properly drawn. Plaintiffs argue that there is no legitimate state interest underlying Measure 16, because statistics show that only 2-4% of the terminally ill actually commit suicide. However, as noted, a classification is valid for equal protection purposes as long as there is some "fit" between the disparate treatment and the legislative purpose. On the other hand, intervenor defendants argue that Measure 16 is only the first step toward legalizing physician assisted suicide for others who consent.[3] The Ninth Circuit in discussing whether a

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[3]Certain of the defendants would limit the court's analysis of the constitutional issues to the context of the terminally ill class as defined by Measure 16, and the court has so limited its analysis. Nonetheless, the candor of intervenor defendants boldly presents the underlying issue: what are the boundary lines, if any, to state-sanctioned suicide? While a diagnosis of terminal illness with less that six months to live may be a persuasive rational basis for some to choose suicide, there is little limit to the justifications which can be advanced for state-sanctioned suicide. Where in the Constitution do we find distinctions between the terminally ill with six months to live, the terminally ill with one year to live, paraplegics, the disabled, or any category of people who have their own reasons for not wanting to continue living?

This could be a slippery slope indeed. The Supreme Court has cautiously and explicitly excluded assisted suicide from the scope of its decisions concerning a "right to die." *Cruzan*, 497 U.S. at 280, 110 S.Ct. at 2852. It has identified the considerations for determining when a right "not readily identifiable in the Constitution's text" is deserving of constitutional protection. *Bowers v. Hardwick*, 478 U.S. 186, 191, 106 S.Ct. 2841, 2844, 92 L.Ed.2d 140 (1986). A right must be "implicit in the concept of ordered liberty" so that neither liberty nor justice would exist if it were sacrificed. The right must be "deeply rooted in the Nation's history and tradition." Id.

terminally ill patient had a liberty interest in a "right to die" reasoned:

> If at the heart of liberty protected by the Fourteenth Amendment is the uncurtailable ability to believe and to act on one's deepest beliefs about life, the right to suicide and the right to assistance in suicide are the prerogative of at least every sane adult. The attempt to restrict such rights to the terminally ill is illusory. If such liberty exists in this context, . . . every man and woman in the United States must enjoy it. . . . The conclusion is a *reductio ad absurdum*. . . .

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at 191-192, 106 S.Ct. at 2844. Courts have considered the historical treatment of suicide in analyzing an alleged constitutional right to assisted suicide, and states have traditionally penalized acts of suicide and assisted suicide. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. at 294-295, 110 S.Ct. at 2859-60 (Scalia, J., concurring). Traditionally, physician assisted suicide has been regarded as contrary to the Hippocratic Oath which states in part:

> To please no one will I prescribe a deadly drug, nor give advice which may cause his death.

STEADMAN'S MEDICAL DICTIONARY (5th Unabridged Lawyers' Ed), at 650.

It is noteworthy that the Declaration of Independence refers to life as "inalienable," presumably a benefit that cannot be easily waived or forfeited. The Ninth Circuit recognized that: "[t]ort law and criminal law have never recognized a right to let others enslave you, mutilate you, or kill you, even with your consent." *Compassion in Dying*, 49 F.3d at 594.

The Ninth Circuit further stated:

> In two hundred and five years of our existence no constitutional right to aid in killing oneself has ever been asserted and upheld by a court of final jurisdiction. Unless the federal judiciary is to be a floating constitutional convention, a federal court should not invent a constitutional right unknown to the past and antithetical to the defense of human life that has been a chief responsibility of our constitutional government. Id. at 591.

Compassion in Dying, 49 F.3d at 591. While the practical effect of a state law may be to create some inequality between particular classes of persons on the ground that the legislature has taken only one step, it cannot create an illusory classification where the reasons for the law apply equally to all members of the public.

Defendants argue that Measure 16 cannot violate plaintiffs' right to equal protection of the laws, because it does not require any action, rather it merely provides an optional procedure. In theory, the consent embodied in Measure 16 equally protects the right of a terminally ill person to go on living and the right to choose to die. This consent is purportedly based on a person's own rational assessment of the quality and value of their life.

As Measure 16 itself recognizes, however, there may be terminally ill persons who are suffering from impaired judgment and yet express a wish to die. Their status is incompatible with autonomy and personal decisionmaking. Where terminally ill persons are provided the means of hastening death, there is a potential for exposing members of society to life-threatening mistakes and abuses. Therefore, a crucial inquiry under an equal protection analysis is whether the safeguards provided in Measure 16 are sufficient to justify treating terminally ill patients differently than others.

Plaintiffs argue that the "terminally ill" classification denies them equal protection of the laws, because non-terminally ill persons are entitled to certain statutory "protections" under Oregon law which are arbitrarily and irrationally abrogated by Measure 16. Specifically, they point to ORS 163.125, ORS

161.205, ORS 426.070, ORS 677.095, and ORS 677.190.[4] These laws serve to protect vulnerable people who might otherwise seek suicide in response to treatable depression, mental illness, or coercion. After noting that a majority of states have laws imposing criminal penalties on one who assists a suicide, the Supreme Court has stated: "We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death." *Cruzan v. Director, Missouri Dept. of Health,* 497 U.S. 261, 280, 110 S.Ct. 2841, 2852, 111 L.Ed.2d 224 (1990). The state interests underlying these statutes include preservation of life and protection against suicide.

The state defendants claim the following interests in creating an exception for terminally ill persons under Measure 16: (1) avoiding unnecessary pain and suffering;[5] (2) preserving and enhancing the right of competent adults to make their own critical health care decisions; (3) avoiding tragic cases of attempted or successful suicides in a less humane and dignified

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[4]ORS 163.125 establishes the crime of manslaughter in the second degree for recklessly or intentionally causing or aiding another person to commit suicide. ORS 161.205 provides that a person acting under a reasonable belief that another person is about to commit suicide may use reasonable physical force to thwart the result. ORS 677.190(1) provides that the Board of Medical Examiners for the state of Oregon may take disciplinary action against a physician for "unprofessional or dishonorable conduct," which includes any conduct contrary to recognized standards of ethics of the medical profession or which might constitute a danger to the health or safety of a patient. *See also* ORS 677.188(4)(a). Two of these statutes are more fully discussed in the text of this opinion: ORS 426.070 *et seq.*, establishing the procedure for civil commitment, and ORS 677.095, establishing a physician's standard of care.

[5]The court notes that although defendants argue that one purpose of Measure 16 is to end intractable pain, the statute does not require any showing of pain to acquire a lethal prescription.

manner; (4) protecting the terminally ill and their loved ones from financial hardships they wish to avoid; and (5) protecting the terminally ill and their loved ones from unwanted intrusions into their personal affairs by law enforcement officers and others. (Defendants' Reply Memorandum in Support of Motion for Summary Judgment (# 172) at 16).

It is "rational" to conclude that competent terminally ill persons may not want protection from their suicidal impulses. Preventing suicide may simply mean prolonging suffering for a person who has no hope of a significant natural life ahead.[6] Therefore, it may be a valid public policy to allow choice based on principles of autonomy and self-determination — the right to control one's body, destiny, and health care.

The basic premise underlying the state's argument that Measure 16 is constitutional is that terminally ill persons consent to the drug overdose. Thus, the measure excludes the "incompetent" from opting for assisted suicide, because their consent cannot be deemed voluntary or valid. The problem is that the procedures designed to differentiate between the competent and incompetent are not sufficient. For example, one safeguard recognized in withdrawal of life support cases, but not under Measure 16, is the involvement of third parties to provide a "substituted judgment" on behalf of an incompetent person. The third parties, usually family members or relatives, act as proxies to implement what a patient would choose under particular circumstances. *Cruzan*, 497 U.S. at 279-80, 110 S.Ct. at 2852; ORS 127.510(1) (provides that a capable adult may designate in writing a competent adult to serve as attorney-in-fact for health care and to direct withdrawal of life support).

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[6]It is equally "rational" to conclude that a person could never receive a benefit from self-destruction.

Another example is ORS 426.070, which provides a procedure for civil commitment of mentally ill persons who, because of a mental disorder, are dangerous to themselves. *See also* ORS 426.005(1)(d)(A). Under this procedure, a "treating" physician licensed by the Board of Medical Examiners may temporarily hold such individuals in a health care facility for up to twelve hours if that physician believes them to be dangerous to themselves, and in conjunction with a qualified mental health professional, may hold them up to five days. ORS 426.231; ORS 426.232. A judge is required to appoint at least one qualified "examiner" to evaluate the patient and provide a report prior to a commitment hearing. ORS 426.110; ORS 426.120. A qualified examiner is defined as a physician licensed to practice psychiatry or who is certified to make examinations by the Mental Health and Developmental Disability Services Division. ORS 426.110(2)(b). None of these safeguards apply to Measure 16.

Without the protections provided in other situations, Measure 16 requires "attending" and "consulting" physicians who may not be psychiatrists, psychologists, or counselors to make an evaluation whether a condition is causing impaired judgment,[7] if a patient is depressed, or suffering from a psychiatric or psychological disorder. This is the final evaluation for persons, whom the physicians believe, are not suffering from impaired judgment. The Measure also relies on them to decide when a person's request is voluntary and not the product

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[7]Measure 16 defines an "attending" physician as one who is primarily responsible for the care and treatment of a terminal disease. It defines "consulting" physician as one who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a patient's disease. These physicians will be referred to as "treating" physicians for purposes of this opinion. They are required to evaluate whether a patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment. (§ 3.03).

of undue influence.[8] There is no requirement that the person consult a certified social worker or other specialist to explore social services which might assist the person to live in greater comfort. Also, it is the treating physician's responsibility to inform the person of "feasible alternatives," including "comfort care, hospice care and pain control." (§ 3.01(2)(e)).

It is undisputed that one of the factors that motivates suicide is depression. Suicide requests may represent a plea for help by a distraught person in physical and emotional pain. Under Measure 16, a treating physician must determine when a person is beyond help and not merely suffering from treatable depression common in people with terminal illnesses. Seriously ill people commonly suffer from alienation, guilt and feelings of unworthiness. They are susceptible to even subtle suggestions that reinforce these feelings. Clinical imponderables such as severity of pain, gradations of suffering, and prognosticating accurately are difficult in themselves. They may be compounded when a person seeks assisted suicide, or the treating physician is frustrated or inclined to impose their values on a person.[9] The

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[8]Measure 16 does provide some protection from undue influence. Section 4.02(2) provides:

> A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony.

[9]The Ninth Circuit has stated that "[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer." *Compassion in Dying*, 49 F.3d at 592. In addition, it noted that a physician's search for ways to combat disease would be affected, "if killing were as acceptable an option for the physician as curing." *Id.*

The Ninth Circuit recognized that protecting vulnerable patients from psychological pressure to consent to suicide was important. *Id.* It reasoned that for all medical treatments including assisted suicide, physicians decide

problem of inadequate mental evaluation is compounded by imprecision in defining "terminal disease." Even for physicians who specialize in treating a terminal disease, no precise definition is medically or legally possible, since only in hindsight is it known with certainty when someone is going to die. As the Ninth Circuit noted, the terminally ill category is "inherently unstable." *Compassion in Dying*, 49 F.3d at 590.

Measure 16 does not provide for an independently chosen consulting physician to confirm that a person is capable and acting voluntarily, rather it is the attending physician's responsibility to make the referral. (§ 3.01). This does not assure a second, independent medical examination to closely and carefully scrutinize a person's "qualification" to use Measure 16. The Measure provides a person with a short time for reflection, no less than 15 days between the initial oral request and the writing of the prescription and no less than 48 hours between the patient's written request and the writing of the prescription. (§ 3.08). The possibility that a judgment impairing disorder will resolve itself within this short time frame is unlikely.[10] Also, from a broader view, there is no independent

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which patients are candidates. "Physician neutrality and patient autonomy, independent of their physician's advice, are largely myths. . . Once the physician suggests suicide or euthanasia, some patients will feel that they have few, if any alternatives, but to accept the recommendation." *Id.* The court also discussed the particular vulnerability of the poor and the disabled. Finally, the Ninth Circuit mentioned preventing the abuse that occurs in the Netherlands where assisted suicide is permitted in response to repeated requests from a suffering, competent patient.

[10]As noted previously, the classification of a terminally ill patient with six months or less to live is only one of a myriad of classifications which would support a rational basis for a decision to commit suicide. Would the same procedures for determining competency and the same 15 day waiting period withstand constitutional scrutiny as applied to a 19 year old paraplegic contemplating suicide? Again, where in the Constitution do we find the

oversight for the decision and implementation of an assisted suicide request by medical professionals, i.e., review by a probate court, as there is with civil commitment.[11] With death at issue under Measure 16, the court is unable to conceive of a set of facts under which it would be rational to not require mental and social evaluations by appropriately trained professionals.

ORS 677.095 establishes the standard of care for physicians who treat patients outside Measure 16 parameters. It provides, in relevant part: "A physician . . . has the duty to use that degree of care, skill and diligence which is used by ordinarily careful physicians . . . in the same or similar circumstances in the community of the physician . . . or a similar community." An Oregon physician's actions are judged by the generally accepted and ordinary level of skill expected by the medical profession. For example, this standard applies to an Oregon physician's conduct related to withdrawal of life support. ORS 127.560(1)(b). On the other hand, Measure 16 adopts a subjective "good faith" standard of care for a physician's participation under the Act.[12] An Oregon appellate court has

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compass to chart our way through this state-sanctioned dispensation of death?

[11]In fact, under Measure 16 there is no family notification requirement at the point of receiving the physician-prescribed drug. Section 3.05 provides:

> The attending physician shall ask the patient to notify next of kin of his or her request for medication pursuant to this Act. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

[12]Measure 16's "Immunities and Liabilities" section provides in relevant part:

> § 4.01 Immunities
> Except as provided in Section 4.02:
> (1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this Act.

expressly rejected the insertion of the "good faith" concept into the usual consideration of whether physicians exercise reasonable care. *Ellis v. Springfield Women's Clinic, P.C.*, 67 Or.App. 359, 678 P.2d 268, 270, *rev. den.*, 297 Or. 228, 683 P.2d 91 (1984). In remanding for a new trial, the Oregon Court of Appeals stated: "The introduction of that concept allows the jury to consider the motivations of the defendants. Such a consideration has no place in an action for ordinary negligence. . . . " *Id.*, 678 P.2d at 270.

Is there a rational basis for Oregon to immunize physicians from liability for actions taken in "good faith" under Measure

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. . . (3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of this Act shall constitute neglect for any purpose of law. . . .

The "participation" described in Section 4.01(1) includes these acts of the "attending physician":

(1) Making the initial determination whether a patient has a terminal disease (§ 3.01(1));

(2) Making the initial determination whether a patient is capable and has voluntarily made the request for medication to end his or her life (§ 3.01(1));

(3) Informing the patient of the potential risks associated with taking the medication to be prescribed, and the probable result of taking the medication (§ 3.01(2));

(4) Referring the patient to counseling if it is believed a patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment (§ 3.03);

(5) Verifying that the patient is making an informed decision immediately prior to writing the prescription for a lethal dose of medication (§ 3.04); and

(6) Prescribing a lethal dose of medication, except to patients who may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment (§ 3.03).

"Participation" also includes acts of "consulting physicians" in confirming a diagnosis, determining whether a patient is capable of acting voluntarily and has made an informed decision; and the acts of a state licensed psychiatrist or psychologist who performs psychological counseling. (§ 3.02, § 1.01(4), § 3.03).

16, irrespective of any medical community standard which applies to their actions outside Measure 16? The plain inference from Measure 16 is that it is irrelevant whether physicians objectively act reasonably, or instead act negligently. The court finds that there is no set of facts under which it would be rational for terminally ill patients under Measure 16 to receive a standard of care from their physicians under which it did not matter whether they acted with objective reasonableness, according to professional standards. This defect goes to the very heart of the state's reliance on a person's consent to die. The physician is allowed to negligently misdiagnose a person's condition and competency and negligently prescribe a drug overdose, so long as those actions are in "good faith." This distinction in the physician's standard of care under Measure 16 is not rationally related to any legitimate state interest.[13]

Any state interest which underlays Measure 16 is furthered when a person takes a lethal drug dosage. Yet, there is no requirement that the person take the lethal overdose at the time of the prescription or under the supervision of a physician. It provides that the attending physician may prescribe drugs, but does not limit that prescription to drugs which must be ingested. A prescription may be taken intravenously or a physician may establish a device for releasing the drug by a switch or gas mask. These possibilities subject a vulnerable person to potential abuse at the hands of others, and without the person's knowledge or consent. Measure 16 does nothing to ensure that the decision to commit suicide is rationally and voluntarily made at the time of death. As a result, Measure 16 purports to recognize

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[13]Again, to underscore the constitutional defect in Measure 16, one only need contemplate the same procedures as applied to a classification based upon disability. Would the suspension of the duty of reasonable care otherwise owed by a physician to their disabled patient withstand an equal protection challenge to physician assisted suicide for that patient?

a competent terminally ill person's choice to obtain the means to end their life should they commit suicide while competent, incompetent, or unduly influenced at some future time, including hours, days, weeks, or months later. A person decides when, where, and most important, whether to take the prescribed drug without any legal protection.

There is no set of facts under which it would be rational to conclude that a state may sanction providing people the means to commit suicide without consideration of their circumstances at the time of the suicide. This is not simply a matter of an "imperfect fit" between the classification of "terminally ill patient" and a goal of permitting assisted suicide. Given the imprecision and inadequacy of protections leading to the prescription of drugs, the relationship between Measure 16's classification and the goal of permitting assisted suicide is too attenuated without some protection at the time of taking the fatal drug dosage.

Measure 16 provides a means to commit suicide to a severely overinclusive class who may be competent, incompetent, unduly influenced, or abused by others. The state interest and the disparate treatment are not rationally related and Measure 16, therefore, violates the Constitution of the United States.[14]

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[14]Plaintiffs did not file a separate motion for summary judgment. They argued, in effect, that if defendants admitted certain facts related to the adequacy of the Measure 16 safeguards, then they would be entitled to summary judgment. (Plaintiffs' Brief in Opposition to Defendants' & Intervenors' Motions to Dismiss & For Summary Judgment (# 168) at 2-4). The court construes that pleading (# 168) as plaintiffs' motion for summary judgment. It is not necessary to decide factual issues to grant summary judgment in plaintiffs' favor on the equal protection claim.

II. OTHER CLAIMS

It is not necessary to decide motions related to plaintiffs' Due Process (Count Two), Freedoms of Association and Exercise of Religion (Count Five), ADA (Count Three), and void for vagueness (Count Four) claims.

III. CONCLUSION

Individuals and their families and physicians make decisions regarding dying every day, and with limited legal guidance. The fact that people often consult their physicians in this situation is a good argument that assisted suicide is viewed most appropriately as a personal medical matter. Certainly privacy is an important right that people cherish and enjoy.

However, private medical matters become affairs of government when the state sanctions them. It is precisely because the state of Oregon decided to sanction assisted suicide with its irrevocable consequences that the process must withstand constitutional scrutiny.

Measure 16 singles out terminally ill persons who want to commit suicide and excludes them from protection of Oregon laws that apply to others. Residents of Oregon are entitled to protection from committing suicide if found to be a danger to themselves, and after evaluation by a psychiatrist or other state certified mental health specialist. Under this involuntary commitment procedure, "treating physicians," those who treat physical ailments, are not recognized as sufficiently qualified to evaluate their patient's mental impairments, except in emergency and temporary circumstances. Under Measure 16, the very lives of terminally ill persons depend on their own rational assessment of the value of their existence, and yet there is no requirement that they be evaluated by a mental health specialist.

Treating physicians may not be sufficiently qualified alone to evaluate mental impairments for the general public, but are given the significant role of deciding whether their patient may be suffering from a "psychiatric or psychological disorder or depression causing impaired judgment." For some, this is their only and final mental evaluation. In addition, these physicians may make this mental evaluation, and perform other responsibilities under Measure 16 based on a subjective, good faith belief. Contrary to the physician's "reasonable" standard of care for other patients, under Measure 16 there is no bar to a physician acting negligently. In addition, Measure 16 abandons the terminally ill person at the time the physician provides a lethal prescription. It fails to even acknowledge the most critical time, that of death. It provides a means to commit suicide to people who may be competent, incompetent, unduly influenced, and/or abused at the time of death. There is no distinction.

One Supreme Court justice has emphasized the importance of the Equal Protection Clause in protecting persons from substantively unreasonable laws:

> What protects us . . . from being assessed a tax of 100% of our income above the subsistence level, from being forbidden to drive cars, or from being required to send our children to school for 10 hours a day. . . . Our salvation is the Equal Protection Clause, which requires the democratic majority to accept for themselves . . . what they impose on you and me.[15]

Measure 16 withholds from terminally ill citizens the same protections from suicide the majority enjoys. In the process, it has lowered standards and reduced protections to a degree that

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[15]*Cruzan*, 497 U.S. 261, 300, 110 S.Ct. 2841, 2862-63, 111 L.Ed.2d 224 (1990) (Scalia, J., concurring).

there is little assurance that only competent terminally ill persons will voluntarily die. The majority has not accepted this situation for themselves, and there is no rational basis for imposing it on the terminally ill.

One difficulty with Measure 16 is its inability to limit "rational suicide" to the hard cases. The suffering of some competent, terminally ill persons gives rise to compassionate arguments. However, as in other areas of law, people have not been permitted to relinquish important interests without careful scrutiny. In addition, Measure 16 is not just about whether someone can legally commit suicide, rather it concerns suicide with state involvement. The court has considered the extent to which permitting assisted suicides in the hard cases may lead to the premature deaths of terminally ill persons who may actually want to live. With state-sanctioned and physician assisted death at issue, some "good results" cannot outweigh other lives lost due to unconstitutional errors and abuses.

DATED this 3rd day of August, 1995.

/s/ Michael R. Hogan
UNITED STATES DISTRICT JUDGE

[file mark: Aug. 3, 1995]

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

Gary LEE, et al.,	)	
	)	
Plaintiffs,	)	Civil No. 94-6467-HO
	)	
v.	)	OPINION
	)	(Standing)
STATE OF OREGON, et al.,	)	
	)	
Defendants.	)	
	)	

The court must decide the status of parties to assert or defend claims in this action. Plaintiffs are two physicians, four terminally ill or potentially terminally ill patients, a residential care facility, and individual operators of residential care facilities. Defendants include the state of Oregon, the Attorney General for the State of Oregon, a district attorney, members of the Oregon Board of Medical Examiners, Oregon Health Sciences University Hospital (OHSU), and members of the Oregon State Board of Higher Education (collectively state defendants). In addition, this court allowed an Oregon physician and sponsors of Measure 16 to intervene as defendants.

The parties filed other motions relating to standing, intervention, immunity, and adding parties through pleading

amendment which are addressed by this opinion and decided by separate order on this date.

I. STANDING

Defendants argue that plaintiffs lack standing to assert their claims. Article III of the United States Constitution limits the judicial power of federal courts to "cases" and "controversies." U.S. Const., art. III. A party who invokes the court's authority must show that: (1) they have suffered an "injury in fact" or an invasion of a legally-protected interest which is concrete and particularized, and "actual or imminent," (2) there is a causal connection between the injury and the challenged conduct, and (3) it must be likely that the injury will be "redressed by a favorable decision." *Lujan v. Defenders of Wildlife,* 504 U.S. 555, 560-61, 112 S.Ct. 2130, 2136, 119 L.Ed.2d 351 (1992).

Standing distinguishes "a person with a direct stake in the outcome of a litigation — even though small — from a person with a mere interest in the problem." See *United States v. SCRAP*, 412 U.S. 669, 689 n. 14, 93 S.Ct. 2405, 2417, 37 L.Ed.2d 254 (1973). It is not to be placed in the hands of "concerned bystanders," to use simply as a "vehicle for the vindication of value interests." *Id.* However, it is not necessary to demonstrate a specific or immediate harm when challenging the constitutionality of a statute on its face. *Kines v. Day*, 754 F.2d 28, 30 (1st Cir.1985) (citing *Dombrowski v. Pfister*, 380 U.S. 479, 486, 85 S.Ct. 1116, 1120-21, 14 L.Ed.2d 22 (1965)). In some cases, the potential injury may be so severe, i.e., death, that the risk of it occurring at some future time may be sufficient for standing purposes. *Dimarzo v. Cahill,* 575 F.2d 15, 18 (1st Cir.1978), *cert. denied,* 439 U.S. 927, 99 S.Ct. 312, 58 L.Ed.2d 320 (1978). "One need not wait for the [life-threatening event to occur] before concluding that a real and present threat exists." *Id.* This rule applies when a plaintiff

has little control over whether the life-threatening event will occur. *Id.*

A person may have standing to assert a facial challenge to the constitutionality of a statute which has not yet gone into effect. *See Hodel v. Virginia Surface Min. & Reclam. Ass'n*, 452 U.S. 264, 298, 101 S.Ct. 2352, 2371-72, 69 L.Ed.2d 1 (1981); *see also Doulin v. White*, 549 F.Supp. 152, 154 (E.D.Ark.1982) (citing *Blum v. Yaretsky*, 457 U.S. 991, 102 S.Ct. 2777, 73 L.Ed.2d 534 (1982)). There is no precise test for determining the difference between an abstract question and an Article III controversy, rather it is necessarily a question of degree. *Golden v. Zwickler*, 394 U.S. 103, 108, 89 S.Ct. 956, 959-60, 22 L.Ed.2d 113 (1969). The answer also depends on the nature of the constitutional issues and whether ad hoc factual inquiries are necessary. *See, e.g., Hodel*, 452 U.S. at 294-95, 101 S.Ct. at 2369-70.

Courts have found an insufficient connection between an alleged injury and a defendant's future conduct where it is unlikely that a plaintiff could ever be threatened by such conduct. *Golden v. Zwickler*, 394 U.S. 103, 109, 89 S.Ct. 956, 960, 22 L.Ed.2d 113 (1969); *City of Los Angeles v. Lyons*, 461 U.S. 95, 111, 103 S.Ct. 1660, 1670, 75 L.Ed.2d 675 (1983). A plaintiff does not lack standing merely because an injury may be an indirect product of a defendant's conduct. *See Allen v. Wright*, 468 U.S. 737, 757- 58, 104 S.Ct. 3315, 3327-28, 82 L.Ed.2d 556 (1984).

While standing should not depend upon a consideration of the merits of a plaintiff's claim, such a consideration may properly form one basis for a finding that standing is necessary or desirable to advance the constitutional policies at issue. *Frissell v. Rizzo*, 597 F.2d 840, 845 (3rd Cir.), *cert. denied*, 444 U.S. 841, 100 S.Ct. 82, 62 L.Ed.2d 54 (1979). Where the

injury is less tangible than actual physical or financial injury, a standing determination may turn on the court's view of the "sensitivity of the constitutional values in dispute." *Id.*

The court is required to base its decisions concerning the medical conditions of potential parties only on the record presented to it. This applies equally to plaintiffs and the proposed intervening defendants. The record reviewed here includes all of those documents received prior to the hearing on dispositive motions, as well as post-hearing submissions. This may seem insensitive because the medical conditions of these people may have improved or deteriorated between the final submissions to the court and now. The court, however, may not consider any changes that are not reflected in the written record.

The state and intervenor defendants argue that plaintiff terminally ill patients lack standing because they have not demonstrated an actual or imminent injury which is fairly traceable to their conduct. However, the risk of death is a sufficient injury for plaintiffs Eric Dutson and Janice Elsner and properly a basis for standing if sufficiently connected to Measure 16. *See Dimarzo v. Cahill, supra*. Measure 16 requires that a qualified person have an "incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months." (§ 1.01(12)).

Plaintiff Dutson is an AIDs patient who has been given a prognosis of six months to live. (Plaintiffs' Supplemental Statement of Material Facts (# 174)). Plaintiff Elsner has a progressive form of muscular dystrophy and has already lived longer than doctors expected. *Id.* She has suffered clinical depression that resulted in ambivalence about whether she wanted to continue living. (Defendants' Supplemental Statement of Material Facts (# 164)). Both of these individuals have

histories of depression. *Id.* Currently, they are not contemplating suicide and have expressed opposition to assisted suicide to their physicians. However, their medical histories indicate they are likely to become depressed and unable to control the timing or severity of that depression.[1] There is sufficient evidence that plaintiffs Dutson and Elsner are at a significant risk of harm due to circumstances beyond their control with Measure 16 in effect. These plaintiffs have standing to assert a facial challenge to Measure 16. The nature of the constitutional issues they assert does not require resolution on a case-by-case basis.

There is significant evidence in the record that depression is a major cause of suicide and is many times undiagnosed. Measure 16 requires drawing a fine line between rational, depressed terminally ill persons who want assisted suicide and terminally ill persons who express suicidal wishes, but are not capable of rational choice. It is about people who are most vulnerable to undue pressure. It is about permitting physicians to make decisions concerning mental competency and to provide the means by which people end their lives. Oregon's criminal homicide, civil commitment, and physician standard of care and

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[1]On the other hand, the record indicates that plaintiff Jeffrey Weinkauf is a diabetic who takes insulin and is healthy. He has not been given a prognosis of six months to live, has not indicated any desire to commit suicide, and has no history of severe depression. Plaintiff Claudine Stotler was told in 1992 that she had six months to live. (Plaintiffs' Supplemental Statement of Material Facts (# 174)). She has a cancerous lung and liver, and pancreatic and brain tumors. *Id.* Her doctor thought the cancer had metastasized, and that there was nothing further that could be done medically. (Plaintiffs' Supplemental Statement of Material Facts: Plaintiffs' Supplemental Exhibit List, (# 175), Exhibit W at 11). However, the "tumor review board" thought that surgery might help. *Id.* She did undergo multiple surgeries in 1992-1994 and has not received an update on her prognosis. Neither plaintiff Weinkauf or plaintiff Stotler have demonstrated a sufficient threat of harm from Measure 16, and, therefore do not have standing.

disciplinary laws do not apply in equal measure to those who participate in Measure 16. It is difficult, at best, to decide Article III standing based on a terminally ill person's mental status. Plaintiffs Dutson and Elsner should not be denied standing, because they have not become so depressed they want to commit suicide, or until they receive and take a fatal drug dosage and either die or are close to death. As noted in the equal protection opinion, Measure 16 implements a significantly lesser standard of care for physicians. This, itself, would confer standing on these plaintiffs.

Defendants Harcleroad and members of the Oregon Board of Medical Examiners are named as defendants because they have some enforcement responsibilities regarding Measure 16.[2] The alleged injury-producing conduct is their recognition of Measure 16's validity and enforcement of its terms. Defendants' alleged conduct in recognizing and enforcing an unconstitutional statute would be a sufficient indirect cause of any future injury to plaintiffs.

In addition, it is sufficiently likely that plaintiffs Dutson and Elsner would benefit from a judgment in this action. *See Duke Power Company v. Carolina Environmental Study Group,* 438 U.S. 59, 98 S.Ct. 2620, 57 L.Ed.2d 595 (1978); *Bryant v. Yellen*, 447 U.S. 352, 100 S.Ct. 2232, 65 L.Ed.2d 184 (1980); *University of California v. Bakke*, 438 U.S. 265, 98 S.Ct. 2733,

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[2]The evidence indicates that it is unlikely that plaintiffs Dutson or Elsner would become patients of OHSU. Both testified at their depositions that they did not expect to become OHSU patients in the future. (Supplemental Affidavit of Stephen K. Bushong (# 165), Exhibit A at 24, Exhibit B at 18). Any future injury to them due to Measure 16 would not be fairly traceable to OHSU, its president, Peter Kohler, or members of the Oregon State Board of Higher Education. *See Golden v. Zwickler, supra; City of Los Angeles v. Lyons, supra.* Plaintiffs lack standing to assert their equal protection claims against these defendants.

57 L.Ed.2d 750 (1978). Their claims are ripe. It is difficult to imagine a legal proceeding with more sensitive constitutional values at issue. It is important that plaintiffs have standing to advance their constitutional positions.

II. INTERVENORS

Certain terminally ill persons have moved to intervene as defendants. Fed.R.Civ.P. 24(a) provides that parties have a right to intervene when they are "so situated that the disposition of the action may as a practical matter impair or impede the applicant's ability to protect that interest, unless the applicant's interest is adequately represented by existing parties." Fed.R.Civ.P. 24(b) permits parties to intervene when their claim or defense and the main action have a question of law or fact in common. Myriam Coppens and Nancy Dorr move to appear as *amicus curiae*. Coppens is a certified nurse practitioner, licensed marriage family therapist, and adjunct professor. She has taken difficult calls from suicidal people for several years. The interests Coppens and Dorr seek to represent in an *amicus* capacity are adequately covered by other named defendants, and their intervention is, therefore, unnecessary.

Dorr, Anthony Lynde, Tim Shuck, and Merrill Yukich all allegedly have "terminal illnesses" as defined by Measure 16. Shuck has AIDs and the virus has traveled to his brain. He has a prognosis of less than six months to live. (Defendants' Memorandum in Opposition to Motion for Preliminary Injunction (# 69), Affidavit of Timothy W. Shuck). Lynde has been diagnosed with bone cancer that currently is in remission. Prior to its remission, he experienced considerable pain. (*Id.*, Affidavit of Anthony A. Lynde). Dorr has breast cancer that has metastasized to the sternum. She expects to undergo high dosage chemotherapy with a bone marrow rescue. (*Id.*, Affidavit of Nancy Dorr). Yukich has lung cancer. Her doctor has

informed her that she has a 20% chance to live one year, and if still alive, her chances for full recovery improve with each subsequent year.

Neither Lynde, Dorr, or Yukich have been given prognoses of six months to live. They argue that it is not necessary for them to be "qualified patients" under Measure 16 to have standing, because their interest is to protect the peace of mind of knowing they can obtain a lethal prescription in the future. Shuck is allowed to intervene because he has sufficiently demonstrated an interest to protect. The interests of Lynde, Dorr, and Yukich are adequately represented by other named parties, and intervention is not necessary.

Intervenor defendant Dr. Levin argues that plaintiff physicians Lee and Petty do not have third party standing to assert claims on behalf of their patients. This court found such third party standing for purposes of the preliminary injunction and is asked to reconsider based on a more complete record. A party who wishes to assert third party standing must demonstrate an injury in fact. *Singleton v. Wulff*, 428 U.S. 106, 114, 96 S.Ct. 2868, 2874, 49 L.Ed.2d 826 (1976). This court previously relied on direct financial impact as the basis for the physicians' injury in fact, based on *Singleton, supra*. However, intervenor defendant Dr. Levin has submitted evidence that the plaintiff physicians do not currently have patients who wish to request a Measure 16 prescription. Even if they did, these physicians are opposed to Measure 16 and would not have a sufficient personal stake to represent the interests of their patients who seek assisted suicide. *See Akron Center for Reproductive Health v. City of Akron*, 651 F.2d 1198, 1210-11 (6th Cir.1981), *cert. denied*, 456 U.S. 989, 102 S.Ct. 2268, 73 L.Ed.2d 1283, *judgment aff'd in part, rev'd in part*, 462 U.S. 416, 103 S.Ct. 2481, 76 L.Ed.2d 687 (1983). Any alleged financial loss must, therefore, be based on a decrease in "the pool of potential

fee-paying patients." This is an inadequate basis for third party standing.

III. DISMISSAL

Defendants argue that claims by the individual administrators of the residential care facilities should be dismissed. Fritz and June Beck own the plaintiff Willows Residential Care Facility. Sister Bernards is the administrator of Maryville Nursing Home. Their claims are dismissed to the extent they are asserted on behalf of the patients of the respective residential care facilities. The corporate facilities are the real parties in interest for purposes of asserting such claims. However, the individual administrators are entitled to assert First Amendment claims.

Defendants argue that the constitutional claims against the state of Oregon, the Oregon Attorney General, and OHSU should be dismissed on Eleventh Amendment immunity grounds.[3] In addition, they argue that claims against the Attorney General should be dismissed because they are not justiciable.

The Eleventh Amendment generally prohibits a federal court from exercising jurisdiction over a nonconsenting state defendant. *Pennhurst State School & Hospital v. Halderman,* 465 U.S. 89, 104 S.Ct. 900, 79 L.Ed.2d 67 (1984). The Eleventh Amendment is an explicit limitation on federal judicial power and applies to the state and its agencies "regardless of the nature of the relief sought." *Id.* at 100, 104 S.Ct. at 908. It

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[3]The 1995 Oregon Legislature passed Senate Bill 2 which establishes OHSU as an independent public corporation. Its effective date was July 1, 1995. Defendants have failed to demonstrate that Eleventh Amendment immunity applies to OHSU in its new status as a public corporation.

bars federal courts from deciding claims against a state and its agencies unless the state has "unequivocally expressed" its consent to suit or there is an "unequivocal expression of congressional intent" to abrogate Eleventh Amendment immunity. *Id.* at 99, 104 S.Ct. at 907. It is undisputed that the state of Oregon has not consented to be sued nor has Congress abrogated the states' immunity from civil rights claims. Individual state officers who do not have a sufficient connection with the enforcement of a law may be covered by Eleventh Amendment immunity. *Ex parte Young,* 209 U.S. 123, 157, 28 S.Ct. 441, 452- 53, 52 L.Ed. 714 (1908); *Fitts v. McGhee*, 172 U.S. 516, 529-30, 19 S.Ct. 269, 274-75, 43 L.Ed. 535 (1899). In addition, the Attorney General's authority under Oregon law "does not make the alleged injury fairly traceable to his action" as required by Article III. *Southern Pac. v. Brown*, 651 F.2d 613 (9th Cir.1980); *Long v. Van de Kamp,* 961 F.2d 151, 152 (9th Cir.1992). Any claim against the Attorney General based on the enforcement or nonenforcement of the criminal laws is not a justiciable case or controversy. *Id.*

Plaintiffs argue that it is appropriate to name Attorney General Kulongoski a defendant, because he does have enforcement and investigatory powers when ordered to use them by the Governor, and the Governor is also a party. Plaintiffs rely on *Quill v. Koppell,* 870 F.Supp. 78, 79 (S.D.N.Y.1994). However, the Governor has not directed the attorney general to enforce Measure 16. (Affidavit of Theodore R. Kulongoski (# 143)). Plaintiffs also claim that the attorney general is properly a defendant because he has issued a legal opinion regarding Measure 16, and that this role is sufficient. The court does not agree. Plaintiffs' constitutional claims against the State of Oregon, the Governor, and the attorney general are barred by Eleventh Amendment immunity. In addition, the claims against the attorney general are dismissed for lack of justiciability.

IV. CONCLUSION

The appropriate parties to assert or defend claims in this action are:

1. Plaintiff terminally ill patients Eric Dutson and Janice Elsner,

2. Plaintiffs Maryville Nursing Home and Willows Residential Care Facility,

3. Plaintiffs Dr. Petty, Fritz, and June Beck, and Sister Bernards, for First Amendment claims only,

4. Defendants District Attorney Harcleroad, and members of the Oregon Board of Medical Examiners,

5. Intervenor defendants Goodwin, Lee, and Sinnard,

6. Intervenor defendant Dr. Levin, and

7. Intervenor defendant Tim Shuck.

DATED this 3rd day of August, 1995.

/s/ Michael R. Hogan
UNITED STATES DISTRICT JUDGE

[file mark: Apr. 11, 1997]

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

GARY LEE, M.D. individually and on behalf of his patients; WILLIAM PETTY, M.D., individually and on behalf of his patients; ERIC DUTSON, individually and as co-representative of a class of persons who have the disability of a terminal disease even with medical treatment; JANICE ELSNER, individually and as co-representative of a class of persons who have the disability of a terminal disease even with medical treatment; CLAUDINE STOTLER, individually and as a representative of a sub-class of person who have the disability of a terminal disease even with medical treatment and who are being, or will be treated at the Oregon Health Sciences University Hospital; JEFFREY M. WEINKAUF, individually and as a representative of a class of Oregon patients who have a possibly terminal disease absent medical treatment; FRITZ BECK; JUNE BECK; THE WILLOWS HOME, INC.; SISTER GERALDINE BERNARDS, individually and as Administrator of Maryville Nursing Home, Inc.; and

MARYVILLE NURSING HOME, INC., Plaintiffs-Appellees, Cross-Appellants	)	
	)	Nos. 95-35804,
vs.	)	95-35805,
	)	95-35854,
STATE OF OREGON; DOUGLAS F. HARCLEROAD, in his official capacity as the District Attorney for Lane County, Oregon, and as a representative of the class of all district attorneys in the State of Oregon; JOHN KITZHABER, in his official capacity as Governor of Oregon; TERRY L. CONNOR, D.O., in his official capacity as Chairman of the Oregon Board of Medical Examiners; EDWARD A. HEUSCH, D.O., in his official capacity as Vice-chairman of the Oregon Board of Medical Examiners; CATHERINE M. NATER, in her official capacity as Secretary of the Oregon Board of Medical Examiners; JOHN W. GRIGSBY, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; SARAH S. HENDRICKSON, M.D., in her official capacity as a member of the Oregon Board of Medical Examiners; GEORGE A. PORTER, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; JAMES H. SAMPSON, M.D., in his official capacity as a member of the	)	95-35948, 95-35949 (cross appeal)
	)	ORDER

Oregon Board of Medical Examiners; ROSEMARY C. LEE SELINGER, M.D., in her official capacity as a member of the Oregon Board of Medical Examiners; FRED R. STARK, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; MARALYN E. TURNER, in her official capacity as a member of the Oregon Board of Medical Examiners; J. BRUCE WILLIAMS, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; PETER KOHLER, in his official capacity as the President of the Oregon Health Sciences University; LEE SWANSON, JR., HERBERT ASCHKENASY, ROBERT L.R. BAILEY, DIANE CHRISTOPHER, BOBBY LEE, WALTER R. MILLER, ESTHER PUENTES, GEORGE E. RICHARDSON, JR., RONDA L. TROTMAN REESE, JIM WILLIS, AND JANICE J. WILSON, in their official capacities as members of the Oregon State Board of Higher Education; and OREGON HEALTH SCIENCES UNIVERSITY HOSPITAL,

Defendants-Appellants, Cross-Appellees

and

PETER GOODWIN; BARBARA COOMBS LEE; ELVEN SINNARD; MICHAEL VERNON; TED LEVIN; and TIM SCHUCK,
Intervenors-Appellees, Cross-Appellees.

BEFORE: GOODWIN and BRUNETTI, Circuit Judges, and KING,[4] District Judge.

Appellees and cross-appellants' petition for rehearing is DENIED.

[4]Hon. Samuel P. King, Senior United States District Judge for the District of Hawaii, sitting by designation.

**[Oregon Ballot Measure 16
is set out as an appendix to the
Ninth Circuit opinion,
supra at 16a.]**

Nos. 95-35804, 95-35805, 95-35854, 95-35948, 95-35949

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

[file mark: Mar. 13, 1997]

GARY LEE, M.D., et al.,
Plaintiffs-Appellees / Cross Appellants,
&
FRITZ BECK, JUNE BECK, and SISTER GERALDINE BERNARDS,
Plaintiffs-Appellees,
v.
STATE OF OREGON, et al.,
Defendants-Appellants / Cross Appellees,
&
PETER GOODWIN, BARBARA COOMBS LEE, ELVEN SINNARD, TED LEVIN, and TIM SCHUCK
Intervenors-Appellants / Cross Appellees

Appeals from the United States District Court
for the District of Oregon, No. CV-94-06467-MRH

PETITION FOR REHEARING

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* * *

PETITION FOR REHEARING

Appellees and Cross Appellants Lee et al. petition for rehearing pursuant to FRAP 40, Circuit Rule 40-1, and the instructional memorandum from the Office of the Clerk.

STATEMENT OF COUNSEL

The undersigned counsel express their belief, based upon a reasoned and studied professional judgment, that the panel deciding this case has overlooked the following material points of fact or law in the decision:

1. In deciding that the health care providers have no standing, the panel overlooked criminal and malpractice liability for noncompliance with Measure 16. *See* § I.

2. In deciding that the case of the health care providers is not ripe, the panel overlooked criminal and malpractice liability for noncompliance with Measure 16. *See* § II.

3. In deciding that terminally ill patients with a history of depression have no standing, the panel overlooked the fact that a lowered standard of care, an increased risk of harm, a loss of legal redress, and a badge of inferiority are sufficient harms for standing. *See* § III.

4. In deciding that terminally ill patients with a history of depression have no standing because their risk is not more imminent, the panel overlooked the applicable supreme court precedent for cases of this nature. *See* § IV.

5. Because the terminally ill patients have standing, the health care provider plaintiffs ought to be able to assert jus tertii

standing for their terminally ill patients with a history of depression. *See* § V.

6. In deciding that the health care provider plaintiffs have no standing because Measure 16 itself did not require informed consent dialogues, the panel overlooked the fact that the duty, regardless of its source, created an imminent, concrete, and particularized injury. *See* § VI.

7. In opining that plaintiffs probably would not meet the causation and redressability elements of standing, the panel misapprehended the fact that both clearly exist. *See* § VII.

ARGUMENT

I. In Deciding That the Health Care Providers Have No Standing, the Panel Overlooked Criminal and Malpractice Liability for Noncompliance with Measure 16.

The panel held that the health care plaintiffs "lack standing to bring this [forced participation] claim because Measure 16 does not provide for any penalty, criminal or otherwise, for violations of the challenged provisions." Slip op. at 2072. In so doing, the panel overlooked the fact that the health care plaintiffs would be subject to malpractice liability, Or. Rev. Stat. § 677.095 (objective duty of care imposed), and, under Measure 16, to criminal liability. Measure 16 provides:

> The penalties in ORS 127.800 to 127.897 [Measure 16] do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of ORS 127.800 to 127.897.

§ 4.02(4); Or. Rev. Stat. § 127.890(4). Measure 16 thus specifically contemplates criminal liability for conduct inconsistent with it even if the Measure itself neither contains a specific penalty for, nor specifically classifies, such conduct.

Moreover, Or. Rev. Stat. § 161.555(3) provides:

> An offense defined by a statute of this state, but without specification as to its classification or as to the penalty authorized upon conviction, shall be considered a Class A misdemeanor.

A Class A misdemeanor may be punished by up to one year in prison, Or. Rev. Stat. § 161.615(1), and/or up to a $5,000 fine. Or. Rev. Stat. § 161.635(a).[5]

The panel erred because, even apart from medical malpractice liability, it overlooked the fact that the health care plaintiffs would be subject to criminal liability for failure to conform to the requirements of Measure 16. The panel determined that such "an asserted injury would probably be sufficiently 'imminent' for purposes of standing," citing case law that says one need not

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[5]A possible objection needs to be dealt with in advance. Oregon law provides that "[a]n offense is conduct for which a sentence to a term of imprisonment or a fine is provided by any law of this state or by any law or ordinance or a political subdivision of this state. An offense is either a crime or a violation or an infraction." Or. Rev. Stat. § 161.505. Thus, it might be argued that since conduct by health care providers inconsistent with Measure 16 is not specifically penalized, it is not an "offense" — and therefore does not fall within the purview of Or. Rev. Stat. § 161.555(3), which employs the word "offense" as its operative term. Such an argument fails, however, both because it is circular and because it would render Or. Rev. Stat. § 161.155(3) meaningless: the provisions of Or. Rev. Stat. § 161.155(3) were specifically included in Oregon law to provide for penalties for conduct not otherwise penalized by imprisonment or fine under Oregon law.

"risk arrest or prosecution in order to have standing to challenge the constitutionality of a criminal statute." Slip op. at 2072 (citation omitted). Under the threat of criminal prosecution for failure to comply with Measure 16, the health care providers have standing.

II. In Deciding the Case of Health Care Providers Is Not Ripe, the Panel Has Overlooked Criminal and Malpractice Liability for Noncompliance with Measure 16.

With respect to the health care plaintiffs, the same risk of criminal and malpractice liability mentioned in the preceding section was also overlooked by the panel when it determined that the plaintiffs' claim was not ripe because they faced, "at worst, . . . a civil enforcement action." Slip op. at 2073.

III. In Deciding that Terminally Ill Patients with a History of Depression Have No Standing, the Panel Overlooked the Fact that a Lowered Standard of Care, an Increased Risk of Harm, a Loss of Legal Redress, and a Badge of Inferiority Are Sufficient Harms for Standing.

The panel held that the terminally-ill plaintiffs did not have standing to raise an equal protection challenge despite the lower standard of care to which they were subjected by Measure 16 because "the mere reduction in the standard of care owed by doctors to their terminally-ill patients is insufficient to confer standing without an allegation that an individual patient has suffered or will imminently suffer some concrete and particularized injury as a result of the reduction in the standard of care." Slip op. at 2071 n.5.

The panel misapprehended the argument, for the lowered standard of care is itself a concrete and particularized injury, making terminally ill persons second class citizens subject to a lower standard of care in the full scope of their medical care, including diagnosis of terminal illness, diagnosis of depression, and prescription of medication. An injury is an injury, regardless of its size. *Cf. Everson v. Board of Education*, 330 U.S. 1, 48-49 (1947) (Rutledge, J., dissenting). Moreover, the panel ignored the decision of the Oregon Supreme Court rejecting any lowered, subjective standard of medical care. *Rogers v. Meridian Park Hospital*, 307 Or. 612, 772 P.2d 929 (Or. 1989) (en banc).

The panel ignored the fact that the increased risk of harm the terminally ill plaintiffs suffer because of the lowered standard of care is itself a cognizable injury for standing purposes. *DiMarzo v. Cahill*, 575 F.2d 15, 18 (1st Cir. 1978), *cert. denied* 439 U.S. 927 (1978) (prison inmates at increased risk of fire hazard did not need to prove imminent threat of fire for standing).

The panel also ignored the fact that the lowered standard of care stripped the terminally-ill plaintiffs, their estates, and their families of legal redress, which is a concrete and particularized injury. For example, if a patient believed to be terminally ill who is in the midst of undiagnosed depression requests assistance in suicide — an imminently likely (not merely remotely possible) event given the evidence from suicidology experts presented in the record and in the appellees' and cross appellants' brief on appeal (but overlooked by the panel) — the standard of care afforded her in (1) the diagnosis of whether she is terminally ill, (2) the evaluation of whether she is capable of making a fully rational and volitional decision, and (3) the provision to her of a prescription intended to be efficiently lethal are all governed by a good-faith, subjective standard,

rather than the usual obbjective standard of medical care. This deprives her and those making legal claims as a result of her injury and/or demise of legal remedies in the form of medical malpractice claims, criminal charges, civil charges such as battery, and disciplinary charges.

The panel also overlooked the fact that Oregon has imposed on terminally ill patients a badge of inferiority, making them second class citizens by allowing them to have assisted suicide, something considered so dangerous and wrong that it is prohibited to all other Oregon citizens. For terminally ill persons, however, the state has decided not to assert its unqualified interest in protecting human life. This discrimination is in the nature of racial apartheid, in that the mere classification of persons into groups with differing legal protections on the basis of the disability of terminal illness is an injury. *See Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 448, 450 (1985).

IV. In Deciding that Terminally Ill Patients with a History of Depression Have No Standing Because Their Risk of Death Against Their Will Is Not More Imminent, the Panel Overlooked the Applicable Supreme Court Precedent for Cases of This Nature.

In rejecting Ms. Elsner's standing based on the panel's characterization of the District Court's holding on standing, the panel rejected the notion that the standing of Ms. Elsner should be recognized because "there was a danger Elsner would only have standing after she was dead or close to death, and that if Elsner did not have standing, nobody would." Slip op. at 2069. The panel decided that Elsner's threat of danger was "so speculative" that the described rationale for Elsner's standing was "almost as applicable to every individual in the State of Oregon." *Id.*

The panel is wrong as to the terminally ill patients' legal standing on the basis of their imminent risk for assisted suicide itself. The panel ignored the point of the first rationale of the district court, namely, if a terminally ill person with a history of depression does not have standing to challenge a statute which imposes on her a lower standard of care and may have lethal consequences then only a similarly-situated person who *also* met one of the following criteria would have standing: (1) suicidal depression has gone undiagnosed due to the flawed safeguards and the depression has caused the patient to actually request and receive a lethal prescription or (2) suicidal depression has gone undiagnosed, assistance in suicide has occurred, and the personal representative has challenged the statute.

Expecting a person in the first situation to bring suit is ludicrous. No person in such a condition could or would bring suit due to the depression and the fact that she is receiving what she wants, i.e., assistance in suicide.

The second situation asks a person to await death so that her personal representative may challenge the statute responsible for the death. Such relief gives little benefit to the deceased person. If one need not await a criminal charge to challenge a statute, then one ought not have to await death.

The panel's facile dismissal of the terminally ill patients with the comments that (1) their harm is not sufficiently imminent and (2) just because no one has standing doesn't mean someone has to have standing, slip op. at 2069, overlooks what the district court clearly saw, namely, this sort of case is classically sui generis and calls for a most careful application of the principles underlying the standing rules.

The analysis must begin with the U.S. Supreme Court's observation in *Cruzan v. Director, Missouri Dept. of Health*,

497 U.S. 261 (1990), in the context of withdrawing life-sustaining nutrition and hydration which would lead to death:

> We think it self-evident that the interests at stake in the instant proceedings are more substantial, both on an individual and a societal level, than those involved in a run-of-the-mine civil dispute. . . . An erroneous decision not to terminate results in maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science . . . . *An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible to correction.*

Id. at 283 (emphasis added).[6]

The principle is that special notice must be taken of the seriousness of the consequences in determining applicable rules of law, and safeguards must be more stringent as the risks grow greater. This fundamental principle of law is applicable to Measure 16, both as to the substantive safeguards allegedly protecting incompetent persons from self harm and assistance in suicide and as to the principles governing who has standing to

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[6]The Supreme Court continued, taking note of the fact that in certain cases the substantive risks are so high that adjustments must be made in the law to protect those rights:

> In *Santosky*, one of the factors which led the Court to require proof by clear and convincing evidence in a proceeding to terminate parental rights was that a decision in such a case was *final and irrevocable*. *Santosky*[*v. Kramer*], 445 U.S. [745,] 759 [(1982)]. . . . The same must surely be said of the decision to discontinue hydration and nutrition of a patient such as Nancy Cruzan which all agree *will result in her death*.

Cruzan, 497 U.S. at 283 (emphasis added). The Supreme Court catalogued the progressive range of standards of proof required by the Due Process clause as the seriousness of the matter at issue increased. *Id.* at 282-83.

seek judicial review the safeguards. With death at issue, and assistance in death for incompetent persons more specifically at issue, it is unthinkable that in a constitutional government there should be no one with standing to seek judicial review of serious claims of such dire and invidious discrimination.

The United States Supreme Court has held that in unique circumstances, comparable to the present one, the rules of standing must be applied with circumspect attention to their purposes, not with a mechanical recitation of the application of the rules in ordinary cases. The Supreme Court's approach is seen clearly in the cases where taxpayers where taxpayers have been permitted to challenge violations of the Establishment Clause.

Such standing was not initially recognized as appropriate by the Supreme Court. In the case of *Valley Forge Christian College v. Americans United for Separation of Church and State*, 454 U.S. 464 (1982), the Court rejected taxpayer standing to challenge a transfer of federal property to a religious organization without compensation in language substantially similar to that of the panel in the present case. The Court forcefully rejected the lower court's "conviction that the enforcement of the Establishment Clause demands special exceptions from the requirement that a plaintiff allege "'distinct and palpable injury to himself,' . . . that is likely to be redressed if the requested relief is granted."" *Id.* at 488 (citations omitted). The Court repudiated the view it saw in a concurring opinion of the lower court that:

> To satisfy "the need for an available plaintiff," and thereby to assure a basis for judicial review, respondents should be granted standing because, "as a practical matter, no one is better suited to bring this lawsuit

> and thus vindicate the freedom embodied in the Estab lishment Clause."

Id. at 489 (citations omitted). The Court rolled out the well-known quote that "[t]he assumption that if respondents have no standing to sue, no one would have standing, is not a reason to find standing," *id.* at 489 (citation omitted), and concluded with the declaration that it would not "countenance such a departure from . . . Article III . . . ." *Id.* at 489-90.

Justices Brennan, Marshall, and Blackmun dissented, with an argument which would later be adopted by the Court itself. Justice Brennan noted the impulse to avoid difficult legal questions by a resort to 'standing to slam the courthouse door against plaintiffs who are entitled to full consideration of their claims on the merits.'" *Id.* at 490 (citation omitted). He observed how the majority "waxe[d] eloquent" about standing principles, but that "*not one word is said about the Establishment Clause right that the plaintiffs seek to enforce.*" *Id.* at 491 (emphasis in original). After recounting the basic requirements of Article III standing, he noted that "the existence of Art. III injury 'often turns on the nature and source of the claim asserted.'" *Id.* at 491-92, *quoting Warth v. Seldin*, 422 U.S. 490, 500 (1975). He continued, "To construe that Article to deny standing 'to the class for whose sake [a] constitutional protection is given,' simply turns the Constitution on its head." *Id.* at 493 (citations omitted). He noted that "'standing is not to be denied simply because many people suffer the same injury,'" *id.* at 496-97, *quoting United States v. SCRAP*, 412 U.S. 669 (1973), and that "the Constitution draws no distinction between injuries that are large, and those that are comparatively small." *Id.* at 497, *citing Everson v. Board of Education*, 330 U.S. 1 (1947) (Rutledge, J., dissenting). He also rejected the majority's concern about "the indirectness of the taxpayer's injury," *id.*, noting that "*as a matter of Art. III standing*, if the causal

relationship is sufficiently certain, the length of the causal chain is irrelevant." *Id.*, *citing Warth v. Seldin*, 422 U.S. at 505 (emphasis in original). Because it was "clear . . . that one of the major purposes of the Establishment Clause was to prevent the use of tax money for religious purposes," he concluded, "*[t]he taxpayer was the direct and intended beneficiary of the prohibition on financial aid to religion.*" *Id.* at 504 (emphasis in original).

This dissenting view became the prevailing view in Justice Brennan's opinion for the Court in *School District of Grand Rapids v. Ball*, 474 U.S. 373 (1985), where taxpayer standing was recognized for an Establishment Clause challenge. The Court specifically noted that the lower court of appeals "recognized no evidence of specific incidents of religious indoctrination in this case [in a program where public school teachers taught some classes in religious schools]." *Id.* at 388. However, the Court spoke of the difficulty there would be for other plaintiffs to recognize and bring a case with specific incidents, including the fact that there would be "no incentive [for others] to detect or report any specific incidents," so that "the lack of evidence of specific incidents . . . is of little significance." *Id.* at 389.

The Supreme Court's approach to the unique situation of the Establishment Clause is the approach taken to the present unique situation by the district court in the passages cited by the panel. The district court correctly applied the principles of standing in this unique situation, while the panel did not. While full development of the parallels is beyond the limited space provided by this petition (and full rebriefing solely on the issue of standing would be in order), the following principles are readily apparent. The notion (*supra*) that a loss of an objective standard of care is to small a harm for standing is erroneous. The notion that specific incidents of harm must already be

occurring for standing to be recognized is erroneous. Just as the protection of taxpayers was a central thrust of the Establishment Clause, so that they have standing, the plain language of the Equal Protection Clause is that "life" is to be protected from equal protection violations, so that those who suffer an increased risk to their lives clearly have standing to challenge the assisted suicide regime which puts them at risk. Finally, the fact that terminally ill patients with a history of depression are the best challengers to an assisted suicide law which would avoid review otherwise absent someone's irreversible death means that in these unique circumstances their standing should be recognized.

V. Because the Terminally Ill Patients Have Standing, the Health Care Provider Plaintiffs Ought to Be Able to Assert Jus Tertii Standing for Their Terminally Ill Patients with a History of Depression.

If, as argued, persons such as Elsner have standing, then the health care providers ought to be able to assert the interests of their patients suffering the same asserted injury as Elsner. Slip op. at 2069.

VI. In Deciding That the Health Care Provider Plaintiffs Have No Standing Because Measure 16 Itself Did Not Require Informed Consent Dialogues, the Panel Overlooked the Fact that the Duty, Regardless of Its Source, Created an Imminent, Concrete, and Particularized Injury.

The panel concluded that one reason the health care provider plaintiffs would not have standing is because their duty to advise patients of the Measure 16 option in informed consent dialogues (which would violate religious liberty rights) arises under existing Oregon statutes (prescribing informed consent),

not Measure 16. Slip. op. at 2072 n.6. The panel has ignored the fact that if Measure 16 did not exist there would be no problem, but because it exists these plaintiffs have an imminent, concrete, and particularized injury, i.e., the moment Measure 16 goes into effect they must provide information to patients about assisted suicide in violation of their religious liberty rights. The panel overlooked these facts when it stated that "[b]ecause this challenge is directed at the informed consent requirements of state and federal law, and does not go to the validity of Measure 16 itself, we do not consider this claim." *Id.* The panel has confused a cause of action with the imminent injury which gives standing. The plaintiffs suffer an imminent injury because of Measure 16, which gives them standing even though Measure 16 does not itself require the informed consent.

VII. In Opining That Plaintiffs Probably Would Not Meet the Causation and Redressability Elements of Standing, the Panel Misapprehended the Fact that Both Clearly Exist.

The panel overlooked the presence of causation and redressability, stating its doubt that these necessary elements of standing also existed. Slip op. at 2070 & n.3. For example, Elsner has several injuries from an unenjoined Measure 16, including a lowered standard of care. This injury would be caused by these officials ignoring the unconstitutional discrimination of Measure 16 and implementing Measure 16 by failing to enforce the existing criminal ban and professional disciplinary ban on assisted suicide. Similarly, this problem would be redressed by an injunction, as the district court's injunction has redressed it to date.

CONCLUSION

For the reasons stated, these appeals should be reheard.

Respectfully submitted,
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Supreme Court, U.S.
FILED
JUN 13 1997
OFFICE OF THE CLERK

(2)

No. 96-1824

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1996

GARY LEE, M.D., *et al.*,
Petitioners,
v.
DOUGLAS F. HARCLEROAD, *et al.*,
Respondents.

On Petition for Writ of Certiorari to the
United States Court of Appeals for the Ninth Circuit

BRIEF *AMICI CURIAE* OF THE UNITED STATES CATHOLIC CONFERENCE; THE CHRISTIAN LIFE COMMISSION OF THE SOUTHERN BAPTIST CONVENTION; THE EVANGELICAL LUTHERAN CHURCH IN AMERICA; THE NATIONAL ASSOCIATION OF EVANGELICALS; THE EVANGELICAL COVENANT CHURCH; THE AMERICAN MUSLIM COUNCIL; THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES; THE CHRISTIAN LEGAL SOCIETY; AND THE CHRISTIAN MEDICAL & DENTAL SOCIETY, IN SUPPORT OF PETITIONERS

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Counsel for a party did not author this brief in whole or in part. No person or entity, other than the *amici curiae* herein, their members, or their counsel made a monetary contribution to the preparation or submission of this brief.

IN THE
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INTEREST OF AMICI

This case involves a law that is both unprecedented and chilling. In 1994, by the narrowest of margins (51 to 49%), the citizens of Oregon voted to remove some of their fellow citizens from the coverage of the criminal and civil laws that protect human life from assisted suicide. Commonly referred to by its number on the ballot, Oregon's Measure 16 not only erects the lethal machinery for taking the lives of those who are sick, depressed, and vulnerable, but also requires that physicians and other health care providers who oppose assisted suicide on religious grounds participate in such conduct by associating with those who have no such objection, by transferring medical records to those who will help the patient take his or her own life, by appointing witnesses necessary for the assisted suicide to take place, and by providing their suicidal patients with information regarding the availability of assisted suicide.

This case therefore represents not only a tragic affront to human life, but an assault upon the religious convictions of countless physicians and health care institutions whose health care goals are deeply opposed to facilitating the taking of human life. Oregon's law has been enjoined since 1994 while a challenge to its validity by, among others, religious health care providers, proceeded. A panel of the United States Court of Appeals for the Ninth Circuit reversed, finding that none of the petitioners -- not the terminally ill patients, nor their physicians, nor other health care providers -- may test the validity of the very law designed to take the patients' lives. Without action by this Court, the rights and lives of the terminally ill will be ended, and the rights of their caregivers will be gravely impaired. This case must go forward now. These amici, representatives of various religious traditions, urge this Court to grant certiorari so that this important case may go forward toward a decision on the merits by the lower courts:

The United States Catholic Conference is a nonprofit corporation organized under the laws of the District of Columbia. Its members are the active Catholic Bishops in the United States. The Conference is a vehicle through which the Bishops speak cooperatively and collegially on matters affecting the Catholic Church and its people. Roman Catholicism is the largest religious denomination in the Nation, with over 61 million members in the United States. The Conference advocates and promotes the pastoral teaching of the Church on diverse issues, including the protection of human rights and the sanctity and dignity of human life.

The Christian Life Commission is the moral concerns and public policy agency for the Southern Baptist Convention, the Nation's largest Protestant denomination, with over 15.2 million members in over 38,000 autonomous local churches. The Commission is charged with addressing public policies affecting the sanctity of human life.

The Evangelical Lutheran Church in America ("ELCA") is the largest Lutheran denomination in North America and the fifth largest Protestant body in the United States. It has approximately 11,000 member congregations which in turn have approximately 5.2 million individual members. Its affiliated Oregon Synod has 123 congregations with 48,748 individual members. On November 11, 1992, the ELCA Church Council, which is the church's board of directors, adopted a "Message on End-of-Life Decisions" stating its opposition to physician-assisted suicide.

The National Association of Evangelicals ("NAE") is a nonprofit association of evangelical Christian denominations, churches, organizations, institutions and individuals. It includes some 42,500 churches from 75 denominations, and 300 parachurch ministries. NAE has joined in this and many other *amicus* briefs in the defense of human life.

The Evangelical Covenant Church ("ECC") is a Protestant denomination with 92,000 members in 600 churches throughout the United States. It operates a university, two hospitals, twelve continuing care and retirement communities, and twelve nursing homes as a Christian ministry. ECC has adopted an ethical guideline on death and euthanasia. The guideline affirms the ECC's commitment to provide "the best palliative measures we can to relieve the pain, discomfort, and suffering of our patients.... We do not act in any way intentionally to cause, assist, or accelerate the death of patients."

The American Muslim Council ("AMC") is a national organization representing the interests of the American Muslim community. AMC is a committed advocate of human rights. It participates in interfaith and multiethnic dialogue with the hope of promoting an environment in which tolerance and justice will thrive. AMC's opposition to assisted suicide is rooted in Islamic belief, which strongly affirms the sanctity of human life.

The Catholic Health Association of the United States is a national Catholic association consisting of U.S. Catholic hospitals and long term care facilities, their sponsoring organizations and systems, and other health and related agencies and services operated as Catholic facilities. CHA's members include approximately 542 Catholic sponsored hospitals, 321 long term care facilities, 61 health care systems, 266 sponsors, which include congregations of Catholic women and men religious and dioceses involved in health care delivery, 262 personal members, and 80 health related organizations. In Oregon, 13 of the State's 71 hospitals, or 18%, are Catholic hospitals.

Founded in 1961, the Christian Legal Society ("CLS") is a nonprofit association of 4,000 Christian attorneys, law professors, and law students with chapters in every state and at 85 law schools. CLS's legal advocacy and information arm, the Center for Law and Religious Freedom, advocates for the protection of religious exercise and the sanctity of human life in federal and state courts nationwide. Many CLS member attorneys must advise health care professionals who have religious objections to collaborating with assisted suicide.

Founded in 1931, the Christian Medical & Dental Society ("CMDS") today has 11,000 members, consisting primarily of practicing physicians in the entire range of medical specialties. Its members share a common commitment to the principles of biblical faith and the integration of those principles with professional practice. Members of CMDS are committed to protecting the lives and best interests of their patients, to ensuring that medicine is practiced conscientiously and in accordance with longstanding Hippocratic principles, and to preserving public respect accorded to physicians as guardians of life and health.

Through their counsel, the parties have consented to the appearance of these *amici*.

SUMMARY OF ARGUMENT

The Oregon law challenged in this litigation not only authorizes and facilitates the assisted suicides of terminally ill patients, but affirmatively requires that physicians and other health care providers participate in such conduct in ways that violate their religious convictions. Those physicians and providers who fail to participate in the process of enabling suicide face a host of penalties -- criminal, civil, and administrative. The Ninth Circuit was wrong when it concluded that religiously-motivated physicians and health care institutions can simply ignore the Oregon law with impunity, and therefore lack standing. They cannot, and so their injury is real and immediate. The religious health care professionals and facilities must now alter their conduct and speech. Protected speech and practices are now jeopardized, and patients' lives are at risk.

We urge this Court to grant certiorari so that this unprecedented case can move forward on its merits.

ARGUMENT

The Need For Plenary Review By This Court Is Extraordinary And Immediate

This case presents two unprecedented questions: (1) whether terminally ill patients may challenge an Oregon law ("Measure 16") that deprives them of the same civil and criminal protections against assisted suicide that benefit all other citizens of the State, and (2) whether physicians and other health care professionals and facilities may challenge that law, which, in violation of their religious convictions and rights of association under the First Amendment and Religious Freedom Restoration Act, forces them both to engage in conduct that facilitates the killing of their own patients and to associate with others who assist patients in committing suicide. The case thus implicates constitutional values of the highest importance: life, free exercise of religion

(including the right of church self-governance), and the right of association.

The first of these values is thoroughly treated in the Petition for Certiorari and in the Brief *Amici Curiae* filed jointly by various disability groups. The amici herein, through previous submissions in cases currently pending before this Court, have also spoken in defense of the constitutional value accorded life in the face of a claimed "right" of assisted suicide. *See* Briefs Amici Curiae in *Washington v. Glucksberg*, No. 96-110 (U.S.), and *Vacco v. Quill*, No. 95-1858 (U.S.). The present brief aims to draw the Court's attention to the immediate and devastating impact Oregon Measure 16 has on the constitutional and statutory rights of physicians and other health care providers,[1] and to the "injury in fact" which they suffer because of it.

To say that the Ninth Circuit gave short shrift to these rights is to improve upon the treatment that the petitioners received in that court. Erroneously and without elaboration, the Ninth Circuit held that the petitioners "lack standing ... because Measure 16 does not provide for any penalty, criminal or otherwise," *Lee v. Oregon*, 107 F.3d 1382, 1391 (9th Cir. 1997), and that their claim was not ripe "[f]or the same reason." *Id.* The Court of Appeals wrote that the petitioners "have not identified any hardship that would befall them if their claims were not considered at this time." *Id.*[2] On the contrary, Measure 16

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[1]Among the many health care providers whose constitutionally protected rights of association and religious freedom are concretely infringed by Oregon Measure 16 are the petitioners, Dr. Gary Lee, Dr. William Petty, Maryville Nursing Home, Sister Geraldine Bernards as Maryville Nursing Home's administrator, The Willows Home, and Fritz and June Beck as the owners of The Willows Home.

[2]As to petitioner nursing homes and their administrators, the Court of Appeals stated only that "[b]ecause these plaintiffs

poses an immediate and direct threat to the very lives of the terminally ill and to the rights of their caregivers. Their injuries are real and immediate, warranting plenary consideration here and in the courts below.

I. Measure 16 Causes Injury To The Rights of Religious Health Care Providers And Institutions.

A. Measure 16 Burdens Rights Of Free Exercise And Association.

The truth of the adage that "rights often turn into duties" is manifest from Measure 16. While purporting to create a "right" to assisted suicide for terminally ill patients, Measure 16 *commands* physicians and other health care providers and institutions either directly to aid in suicide or permit suicide on their own premises; to associate with or allow within their organizational ranks physicians who aid suicides; and to cooperate in assisted suicides by transferring patient records to doctors willing to aid in suicide, providing personnel who will witness the execution of a written directive for aid in suicide, and informing patients of their "right" to assisted suicide -- all in violation of their First Amendment rights of free exercise and association and the Religious Freedom Restoration Act.

This infringement on associational rights and religious liberty occurs in at least four ways:

1. Although health care providers purportedly have no "duty" to participate in assisted suicide,[3] Measure 16 makes it impossible

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have not alleged that there are in fact any doctors at their facilities who will participate in Measure 16's procedures, there is no 'injury in fact' upon which to base standing." 107 F.3d at 1392.

[3]Measure 16, § 4.01(4), reprinted in Pet. App. 30a, states:

for any health care provider, institution, or professional organization to discipline or exclude from its ranks any doctor who assists in suicide, *even on its own premises*. Measure 16, § 4.01(2).[4] This means, for example, that if a staff physician assists a suicide on the premises of a Catholic hospital, the hospital -- notwithstanding sincerely-held religious convictions that forbid assisting a suicide -- can do nothing about it. Physicians with staff privileges at Catholic hospitals typically agree, as part of their contracts, to abide by Catholic ethical directives within the hospital. Thus, in a Catholic hospital, by virtue of his contract a physician may not assist in a suicide. Measure 16 unilaterally modifies and nullifies parts of those agreements by barring Catholic hospitals from censuring, disciplining, or rescinding the privileges of any doctor who assists in a suicide on their premises. Likewise, organizations morally and professionally opposed to assisted suicide, such as amicus Christian Medical & Dental Society, are forbidden under Measure 16 to exclude physicians who assist in suicide from their own membership.

> No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner.

Section 4.01(4), of course, by its terms protects only those who refuse to participate "in the provision" of "medication," and its protections are therefore unavailable to the petitioners whose rights and consciences are violated in other ways.

[4]Section 4.01(2), reprinted in Pet. App. 30a, states:

> No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with this Act.

2. Measure 16 requires physicians knowingly to cooperate in assisted suicide by transferring medical records of suicidal patients to physicians they know will prescribe lethal drugs. Measure 16, § 4.01(4).[5] Physicians whose religious convictions prevent them from assisting a suicide are obligated to provide a physician with the records the latter needs to carry out his patient's death. This is akin to requiring that a person opposed on religious grounds to killing provide a would-be killer with directions to his intended victim's residence.

3. Measure 16 requires long term care facilities to cooperate in assisted suicide by appointing a witness to any resident's written request for suicide. Measure 16, § 2.02.[6] Absent a witness, there can be no assisted suicide. *Id.* Thus, long term care facilities with religious objections to assisted suicide are forced by Measure 16 to operate the regulatory machinery by which the patient's life is intentionally ended.

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[5]Section 4.01(4), reprinted in Pet. App. 30a, states:

> If a health care provider is unable or unwilling to carry out a patient's request [for assisted suicide] under this Act, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

[6]Section 2.02(4), reprinted in Pet. App. 23a, states:

> If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Resources by rule.

4. Measure 16 establishes assisted suicide as a legal "alternative" to curative or palliative treatment for terminally ill patients. Physicians in Oregon are required to inform their patients of such alternatives, Or. Rev. Stat. § 677.097, and even to describe it "in substantial detail" if the patient wants further information. *Id.* Suspension or loss of license awaits the physician who fails to discharge this duty. Or. Rev. Stat. § 677.190(18).

As petitioners have shown (Petition for Certiorari at 26-27), a person who fails to comply with Measure 16 in its various aspects is subject to criminal penalties. Those criminal sanctions in Measure 16 that are applicable to the forgery of a request for assisted suicide, § 4.02(1), and to coercion to commit an assisted suicide, § 4.02(2), "do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of this Act." Measure 16, § 4.02(4), Pet. App. 31a. Under Oregon law, "[a]n offense defined by a statute of this state, but without specification as to its classification or as to the penalty authorized upon conviction, shall be considered a Class A misdemeanor." Or. Rev. Stat. § 161.555(3). Thus, Measure 16 explicitly contemplates criminal penalties for a violation of its requirements, and section 161.555(3) imposes such penalties. Failure to comply with Measure 16 also creates potential malpractice liability. Measure 16, § 4.02(3), Pet. App. 31a ("Nothing in [Measure 16] limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person"). Thus, the health care provider who refuses to execute Measure 16 faces an array of sanctions -- administrative, criminal, and civil. The religious health care professionals and facilities must now alter their conduct and speech. Protected speech and practices are now being chilled.

The conflict between these several requirements of Measure 16 and the religious convictions of many physicians and health care institutions is profound and irreconcilable. In many religious traditions, as well as in the Hippocratic tradition of medical ethics, actions facilitating a patient's suicide involve moral complicity in killing and violate the physician's and institution's mission to serve the life and health of patients.

Abhorrence to any act that facilitates the suicide of any person is reflected in the Christian and Islamic traditions represented by the amici appearing here. By way of example, the Evangelical Lutheran Church in America in 1992 adopted a Message on End-of-Life Decisions in which it stated its "oppos[ition to] the legalization of physician-assisted death, which would allow the private killing of one person by another." The Evangelical Covenant Church has adopted ethical guidelines that state unequivocally that its hospitals and nursing homes "do not act in any way intentionally to cause, assist, or accelerate the deaths of patients."

For Catholic physicians and health care providers, "[t]o concur with the intention of another person to commit suicide and to help in carrying it out through so-called 'assisted suicide' means to cooperate in ... an injustice which can never be excused, even if it is requested." Pope John Paul II, Encyclical Letter *Evangelium Vitae* (*The Gospel of Life*), ¶ 66 (March 25, 1995). Such cooperation "can never be justified...." *Id.* at ¶ 74. Catholic health care professionals therefore have a religious right and duty "to refuse to take part in the phases of consultation, preparation, and execution of these acts against life...." *Id.* Catholic health care institutions "may never condone or participate in euthanasia or assisted suicide in any way." National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* ¶ 60 (1995); *see also id.* ¶ 24 (Catholic health care providers are not to honor an advance directive that is contrary to Catholic teaching).

> Diverse religious traditions oppose assisted suicide and euthanasia because the practices violate the basic value of human life, seen as God's gift.... Many religious traditions reject assisted suicide and euthanasia based on their understanding of general values, including appreciation for the life and value of each individual, the individual's responsibility to the community, and society's obligations towards all of its members, especially the poor and vulnerable.... Differing religious perspectives also share a commitment to compassion for patients and others who are suffering. They believe that this compassion should be expressed by offering care and companionship, not assisted death or medical killing, to the severely ill.

New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 90 (May 1994). These amici, like the citizenry they mirror in their religious convictions, share a common belief in the sanctity of life that unqualifiedly bars them from participating in the macabre machinery Oregon has put in place to end the lives of suicidal, terminally ill patients.

B. The Burdened Rights Are Protected Under The First Amendment And Religious Freedom Restoration Act.

Religious liberty is a fundamental constitutional value, protection of which is especially heightened when, as in this case, it is combined with other First Amendment rights. A law like Measure 16 that burdens *both* religious freedom and the right of association violates the First Amendment unless it is narrowly tailored to achieve a compelling state interest. *Employment Division v. Smith*, 494 U.S. 872, 882 (1990). Unless it meets the same test, a law that burdens religion, alone or in combination with other rights, also violates the Religious Freedom Restoration Act ("RFRA"). 42 U.S.C. § 2000bb, *et seq*.

Measure 16 fails on both counts. First, placing such extraordinary burdens on religious and associational rights serves no compelling interest. Religious freedom is "susceptible of restriction only to prevent grave and immediate danger to interests which the state may lawfully protect," *West Virginia State Bd. of Educ. v. Barnette*, 319 U.S. 624, 639 (1943), such as threats to life, health or property. *Thomas v. Collins*, 323 U.S. 516, 530 (1945); *see Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (vaccination required over religious objection to preserve life and health of an entire community); *Prince v. Massachusetts*, 321 U.S. 158 (1944) (government restrictions on child labor apply even when the labor is religiously motivated). Allowing physicians and other health care providers to refrain from cooperating in or facilitating suicides is certainly no threat to public health and safety. To the contrary, the integrity of the medical profession and the society served by it are gravely threatened by a regime in which doctors and health care institutions are *compelled*, as they are under Measure 16, to facilitate suicides in violation of their religious beliefs and associational rights.

Second, even if Measure 16 advanced some legitimate and truly compelling objective of government, which it does not, it is by no means narrowly tailored to achieve its ends. Oregon proffers no reason why doctors and health care providers morally opposed to killing must personally and institutionally act as accomplices to it.

The right of association is also a fundamental liberty, guaranteed by the First Amendment. *NAACP v. Alabama*, 357 U.S. 449, 460-461 (1958). Interference with such a right by the state is properly subject to the highest degree of scrutiny that a court can apply. *Id.* Here that freedom is coupled with the equally fundamental right of religious bodies to govern and organize themselves. *Watson v. Jones*, 80 U.S. 679 (1872); *Gonzalez v. Roman Catholic Archbishop of Manila*, 280 U.S. 1 (1929); *Kedroff v. St. Nicholas Cathedral*, 344 U.S. 94 (1952);

Serbian Eastern Orthodox Diocese v. Milivojevich, 426 U.S. 696 (1976). For the amici herein, health care is a ministry, part of their religious mission.[7]

"The right to organize voluntary religious associations ... is unquestioned." *Serbian Eastern Orthodox Diocese*, 426 U.S. at 711. Accordingly, it is the function of churches, not government, to determine the qualifications of those who carry out their ministry. *Gonzalez*, 280 U.S. at 16.

By robbing religiously-affiliated health care facilities of the right to extend staff privileges -- privileges that are voluntarily extended and voluntarily assumed -- only to those physicians who will act consistently with their mission, Measure 16 infringes upon the churches' rights of association and self-governance. "There can be no clearer example of an intrusion into the internal structure or affairs of an association than a regulation that forces the group to accept members it does not desire." *Roberts v.*

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[7]The Ethical and Religious Directives that guide Catholic health care ministry, for example, provide:

> The Church has always sought to embody our Savior's concern for the sick. The gospel accounts of Jesus' ministry draw special attention to his acts of healing....
>
> The mystery of Christ casts light on every facet of Catholic health care: to see Christian love as the animating principle of health care; [and] to see healing and compassion as a continuation of Christ's mission....

National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* 3, 4 (1995).

United States Jaycees, 468 U.S. 609, 623 (1984). This Court has never required that the undesirable members be standing inside the organization's doors, *see* n.2 *supra*, before considering such a restriction.

II. The Injury Caused By Measure 16 Satisfies Requirements Of Standing And Ripeness.

Standing involves "a blend of constitutional requirements and prudential considerations." *Valley Forge Christian College v. Americans United for Separation of Church and State*, 454 U.S. 464, 471 (1982). As this Court reiterated just this Term, to satisfy the requirement of standing, "a plaintiff must, generally speaking, demonstrate that he has suffered 'injury in fact,' that the injury is 'fairly traceable' to the actions of the defendant, and that the injury will likely be redressed by a favorable decision." *Bennett v. Spear*, 117 S. Ct. 1154, 1161 (1997), *citing Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-561 (1992); *Valley Forge*, 454 U.S. at 472. In the decision below, the Ninth Circuit held that the petitioners had failed to establish an injury in fact because "Measure 16 does not provide for any penalty, criminal or otherwise, for a violation of the challenged provisions." 107 F.3d at 1391.

The implication left by the Ninth Circuit's decision -- that petitioners are simply free to ignore the challenged provisions of Measure 16 with impunity, and so are not injured by its application -- is plainly wrong. First, as petitioners have shown, failure to comply with Measure 16 triggers criminal liabilities. *See* Petition for Certiorari at 26-27; Measure 16, § 4.02(4), Pet. App. 31a; Or. Rev. Stat. § 161.555(3). Second, any physician or health care provider who fails to carry out its provisions faces disciplinary sanctions by state regulators, including suspension or loss of license, as well as malpractice liability. Petition for Certiorari at 26-27; Measure 26, § 4.02(3), Pet. App. 31a. This Court has never required that a party be the current target of a pending criminal, civil, or administrative proceeding before it will

find standing. This is especially so when one is forced to forego the exercise of a constitutional right or face criminal liability. *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298 (1979), *quoting Steffel v. Thompson*, 415 U.S. 452, 459 (1974); *see also Epperson v. Arkansas*, 393 U.S. 97 (1968).

The petitioners are on the horns of a dilemma. They must either comply with Measure 16 and violate their own constitutionally protected religious beliefs (a decision for which they believe they will be accountable to God), or face the threat of criminal penalties. Under those circumstances, there is unquestionably an injury sufficient to confer standing. *Virginia v. American Booksellers Ass'n*, 484 U.S. 383, 392 (1988) (standing is met where plaintiffs, "if their interpretation of the statute is correct, will have to take significant and costly compliance measures or risk criminal prosecution").

Injury from threatened prosecution is only one injury visited upon these petitioners by Measure 16. Another is the forced association with physicians who assist their patients in committing suicide. Petitioners Maryville Nursing Home and The Willows Home are forced, by virtue of Measure 16, either to associate with (and, indeed, employ and pay) physicians who will assist in suicide, or risk the enforcement consequences. The fact that these facilities will be chilled in their right of association is itself an injury sufficient to create standing. *Broadrick v. Oklahoma*, 413 U.S. 601, 612 (1973). This Court is so protective of the right of association that it even relaxes its usual standing requirements when necessary to prevent the chilling of that right. *Id.*; *Keyishian v. Board of Regents*, 385 U.S. 589 (1967); *United States v. Robel*, 389 U.S. 258 (1967).

Finally, for purposes of standing, Measure 16 creates an injury unique to the Free Exercise context. A regulation forcing one to engage in conduct contrary to one's religious beliefs may be sufficient, in and of itself, to confer standing. *School District of Abington v. Schempp*, 374 U.S. 203 (1963). The injury lies in the compulsion to do what one's religious convictions forbid. *See Association of Data Processing Service Orgs. v. Camp*, 397 U.S. 150, 154 (1970) (a person "may have a spiritual stake in First Amendment values sufficient to give standing to raise issues concerning ... the Free Exercise Clause"). Derogation of one's religious liberties is therefore sufficient injury in and of itself to warrant judicial review.

When challenges are raised to religious symbols and practices in public life, very little has been required for injury sufficient to create standing. The mere allegation that one has to take an alternate travel route to avoid seeing a religious display has been deemed enough to create an "injury" for standing purposes. *Harris v. City of Zion*, 927 F.2d 1401, 1405-06 (7th Cir. 1991), *cert. denied*, 505 U.S. 1218 (1992). This Court has even held that the loss of Medicaid funds to perform abortions is sufficient injury to create physicians' standing. *Singleton v. Wulff*, 428 U.S. 106, 112-113 (1976). The petitioners are not being asked to take an alternative travel route or accept fewer government payments for services they render. They are being forced, in violation of their religious convictions, to alter the way they practice medicine or face criminal, civil, and disciplinary sanctions. If having to drive down a different road or receive reduced government funding for one's services is enough to create an injury for the purpose of standing, then surely being forced to engage in practices which are inimical to the mission of religiously-motivated physicians and health care institutions creates such an injury.

This Court's most recent decision on standing is a reminder that prudential judgment, not hyper-technicality, informs its decision whether a government regulation, like the one at issue here, creates an injury in fact. *Bennett v. Spear*, 117 S. Ct. 1154, 1163-64 (1997) (irrigation districts and ranchers who alleged that the amount of water available to them would be reduced by the government's action alleged injury in fact even though, as the government had argued in that case, there was no demonstration that the petitioners would actually receive less water). The interests here in life, religious liberty, and rights of association and church self-governance occupy a far higher place in the constellation of rights than the private economic interests at issue in *Bennett*. Certiorari should be granted so that this Court can consider fully whether those heightened interests have been transgressed with sufficient concreteness, as we believe they have, to warrant a review of the merits by the lower courts.

For much the same reasons, the present case also presents a controversy that is ripe for resolution. Though conceptually distinct, the concept of ripeness parallels that of standing in important respects.[8] "[R]ipeness turns on 'the fitness of the issues for judicial decision' and 'the hardship to the parties of withholding court consideration.'" *Pacific Gas & Electric Co. v. State Energy Resources Conserv. & Dev. Comm'n*, 461 U.S. 190, 201 (1983), *quoting Abbott Laboratories v. Gardner*, 387 U.S. 136, 149 (1967). This Court has long held that a regulated industry or profession does not have to violate a law and risk penalties before it can challenge the law under principles of ripeness. *Abbott Laboratories*, 387 U.S. at 148-49; *see also Babbitt*, 442 U.S. at 298 (one "does not have to await the

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[8] "Some of the cases expressly recognize that standing and ripeness theories often merge so closely that there is no reason to attempt separation." 13A Charles Alan Wright and Arthur R. Miller, *Federal Practice and Procedure*, § 3532.1 at 131 (2d ed. 1984) (citing cases).

consummation of threatened injury to obtain preventive relief"), *quoting Pennsylvania v. West Virginia*, 262 U.S. 553, 593 (1923). The penalties, described above, are real. The case is ripe. The stakes could not be higher. The "hardship to the parties of withholding court consideration," *Pacific Gas & Electric Co.*, 461 U.S. at 201, could not be more severe. If a health care provider is forced to wait until that moment when a doctor actually assists in a suicide on its premises, or a suicidal patient enters its doorway, before seeking judicial review, then its rights of free exercise and association will have already been violated. Clearly the patient's own rights and life will be extinguished forever.

Important prudential considerations counsel in favor of granting certiorari. If the petitioners are not allowed to go forward, then judicial review of the merits will be thwarted until that day when a health care facility or physician is subjected to prosecution or some other penalty for having failed to help one of his patients commit an assisted suicide. In *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), this Court was so concerned about the irreversible consequences of an erroneous decision about human life that it sustained a higher evidentiary threshold in cases involving termination of life-saving treatment for an incompetent patient. So too, denying certiorari in this case would be unfortunate and unwise, as the terminally ill and their caregivers will then be subjected to an unredressed violation of their constitutional rights. "In some circumstances, counter-vailing considerations may outweigh the concerns underlying the usual reluctance to exert judicial power...." *Warth v. Seldin*, 422 U.S. 490, 500-501 (1975). Those considerations should dispel any reluctance to exert judicial power in this case.

CONCLUSION

For the foregoing reasons, we urge this Court to grant the petition for certiorari and set this case for argument. The judgment of the Ninth Circuit should be reversed and the case should be allowed to proceed on the merits.

Respectfully submitted,

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June 16, 1997

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Supreme Court, U.S.
FILED
JUN 13 1997
CLERK

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No. 96-1824

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

LEE et al., *Petitioners*,

v.

HARCLEROAD et al., *Respondents*.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF *AMICI CURIAE* IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI ON BEHALF OF AMERICAN DISABLED FOR ATTENDANT PROGRAMS TODAY, NOT DEAD YET, WORLD INSTITUTE ON DISABILITY, THE ARC, TASH, NATIONAL SPINAL CORD INJURY ASSOCIATION, INC., AMERICAN FOUNDATION FOR SUICIDE PREVENTION, COMMISSION ON AGING WITH DIGNITY, MICHIGAN HANDICAPPERS CAUCUS & NATIONAL LEGAL CENTER FOR THE MEDICALLY DEPENDENT & DISABLED, INC.

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No counsel for a party authored the brief in whole or in part. The Alliance Defense Fund (Scottsdale, AZ) provided funds to prepare the brief.

INTERESTS OF THE AMICI CURIAE

This case concerns the status of persons with disabilities under Article III of the U.S. Constitution. In particular, it raises the question of whether members of a class segregated according to their disability-related life expectancy may challenge state laws in federal court that encourage only them to request suicide assistance from physicians.

This case will impact the entire disabilities community. Even where proposals to legalize assisted suicide such as Oregon's Ballot Measure 16 ostensibly limit their scope to the "terminally ill", they implicate the interests of a much broader class because "persons suffering from terminal illnesses and those experiencing severe pain almost always meet the definition of individuals with disabilities, and . . . run the risk of being subject to life-shortening measures even when they may not in fact have life-threatening conditions . . . ." National Council on Disability, *Assisted Suicide: A Disability Perspective — Position Paper* (hereinafter "*Position Paper*") at 9 (Mar. 24, 1997).[1]

Most of these proposals define "terminal" so broadly as to sweep within their reach an expansive range of chronic conditions that will result in death in a fixed period of time if basic care is not provided. *See infra* Argument at 16-17. Even if a State enacts a law that defines "terminal" as narrowly as possible, precedents in cases involving treatment refusals will force the courts to expand the eligibility criteria to encompass a much broader range of conditions on equal protection grounds. *See Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 302

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[1]The National Council on Disability has decided "that at this time in the history of the American society it opposes the legalization of assisted suicide." *Position Paper* at 50. Established by Congress under The Rehabilitation Act of 1984 (Pub. L. 98-221) as an independent federal agency, the Council serves as "the principal agency within the federal government charged with the responsibility of providing cross-disability policy analysis and recommendations regarding government programs and policies that affect people with disabilities". *Id.* at Executive Summary.

(Cal. App. 1986) (finding "no practical reason to limit the exercise of this [treatment refusal] right to 'terminal' patients" in case involving person with cerebral palsy); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990) (issuing similar holding in case involving person with injury-related quadriplegia); *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989) (same).

Moreover, laws legalizing assisted suicide will ultimately target the larger class of persons with physical and mental disabilities. For example, Hemlock U.S.A. — the main proponent of legislative change — currently favors limits restricting physician-assisted suicide to the terminally ill, but eighty-two percent of its membership agrees "that Right-to-Die legislation should be written to include the hopelessly ill in addition to the terminally ill." Jeffrey J. Kamakhi & Elaine Fox, Who's Fighting to Die?: A Look at the Hemlock Society Membership 8 (unpublished/undated manuscript included in Hemlock's student information packet, discussing recent survey of 6,398 Hemlock members). Hemlock founder Derek Humphry has recommended that "those of us who sympathize with a justified suicide by a handicapped person" should pursue an incremental approach, because with the enactment of statutes permitting assisted suicide for the terminally ill "will come a more tolerant attitude [toward authorizing suicide assistance for] the other exceptional cases." Derek Humphry, *Final Exit* 62 (1991).

A committee including the chairperson of the Greater Boston Hemlock Society (Nancy Dorfman) recently proposed a comprehensive model statute authorizing physician-assisted suicide for persons with an "intractable and unbearable illness". A Model State Act to Authorize and Regulate Physician-Assisted Suicide, Section 2(d), *in* Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harv. J. Legis. 1, 25 (1996). The model act defines such a condition as "a bodily disorder (1) that cannot be cured or successfully palliated, and (2) that causes such severe suffering that a patient prefers death", and conspicuously omits any limitation based on life expectancy. *Id.*

The authors of the model statute emphasize that this category would include persons with "AIDS, advanced emphysema, some forms of cancer, amyotrophic lateral sclerosis, multiple sclerosis, and many other debilitating conditions", even though they "are not likely to die from their illnesses within six months." Baron et al., 33 Harv. J. Legis. at 11. The authors considered expanding the eligible class even further, but "[co-author] Professor Dan Brock conceded that politics played a significant role in his group's decision not to sanction physician assisted suicide for the chronically mentally ill." John Arras, *News From the Circuit Courts: How Not to Think About Physician-Assisted Suicide*, BioLaw, July-Aug. 1996, at S:171, S:188 n.30.

Legislators have introduced bills based on the model act in Illinois and Massachusetts. Dignity in Dying Act, H.B. 691, 90th Leg., 1st Sess. (Ill. 1997); An Act to Regulate Physician Aid in Dying, H.B. 1543, 180th Leg., 1st Sess. (Mass. 1997). At the present time, these bills refer only to terminally ill persons expected to die within six months, but they can and likely will be amended later to incorporate the model act's more expansive language, and even to apply to persons with chronic mental disabilities. Thus, advocates for assisted suicide are laying the groundwork for enacting assisted suicide laws which stigmatize as better off dead a broadly defined class of persons with disabilities.

Consequently, denying standing to persons with terminal disabilities in this case will serve as precedent for denying standing to the much larger class of persons with disabilities certain to be affected by laws more expansively-drawn than Measure 16. It will also serve as precedent for denying persons with disabilities federal standing to challenge stigmatizing laws generally. The results will be devastating.

Persons with disabilities are protected as a class by, *inter alia*, the Equal Protection Clause of the U.S. Constitution and the Americans with Disabilities Act, 42 U.S.C. §§ 12101-12182 (hereinafter "ADA"). For example, this Court has observed that "[t]he State may not, of course, selectively deny its protec-

tive services to certain disfavored minorities without violating the Equal Protection Clause." *DeShaney v. Winnebago County Department of Social Services*, 489 U.S. 189, 197 n.3 (1989). In particular, disability-based discrimination violates the Equal Protection Clause when motivated by "irrational prejudice", even when "the electorate as a whole, whether by referendum or otherwise" approves it. *City of Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 448, 450 (1984). Moreover, Congress enacted the ADA to strengthen federal protection against disability-based discrimination after finding that persons with disabilities are a discrete and insular minority historically subject to invidious animus. Congress also found that disability-based discrimination persists in such critical areas as "health services . . . and access to public services." 42 U.S.C. § 12101(a)(2).

Persons with disabilities should have every reason to expect the federal courts to hear their complaints, especially those alleging stigmatic injury and brought pursuant to the federal guarantees just described. However, the Ninth Circuit's decision to dismiss this case casts in doubt such assurances; if the decision stands, then it will dramatically limit the ability of all persons with disabilities to vindicate their federal rights, not only in the assisted suicide context, but in all other contexts as well.

Thus, the following Amici have a direct interest in this appeal:

American Disabled for Attendant Programs Today (hereinafter "**ADAPT**") is a national organization and advocate for the rights and interests of persons with disabilities. The majority of its membership consists of persons who have severe disabilities and who have been institutionalized in nursing facilities and other public institutions solely because they have disabilities. ADAPT was a key participant in the political and legislative process that resulted in the passage in 1990 of the Americans with Disabilities Act. *See also ADAPT v. Skinner, U.S. Department of Transportation*, 867 F.2d 1471, 881 F.2d 1184 (3rd Cir. 1989).

Not Dead Yet is a national organization of people with severe disabilities who oppose the legalization of assisted suicide, because it singles out people with significant health impairments for lethal assistance. Not Dead Yet members believe that physician assisted suicide threatens the remaining rights of a profoundly oppressed and marginalized people by exposing this class to the enormous risks of abuse associated with assisted suicide, and by perpetuating invidious social attitudes which hold that death is to be preferred over disability.

World Institute on Disability (hereinafter "WID") is a research, policy, and training center founded in 1983 to work toward independence and equity of opportunity for all people with disabilities, their friends, and families. WID opposes the legalization of physician-assisted suicide given the existing health care climate, social environment, and society's attitudes toward disability. Moreover, the impact of assisted suicide on the rights and interests of persons with disabilities has not been authoritatively researched.

The Arc of the United States (hereinafter "The Arc"), a national organization on mental retardation, is an open membership organization made up of people with mental retardation and their families, friends, interested citizens, and professionals in the disability field. With 140,000 members in 1,100 state and local chapters nationwide, The Arc is the largest voluntary organization devoted solely to working on behalf of the estimated seven million people with mental retardation in the United States and their families. While The Arc does not have a position on physician assisted suicide, The Arc strongly supports the broadest interpretation of standing to allow people with disabilities, including mental retardation, to challenge legislation which has the effect of discriminating or stigmatizing.

TASH is an international organization which champions the unrestricted inclusion of all people, especially those with developmental and/or intellectual disabilities, in all areas of society. TASH has 40 regional chapters and more than 8,000 members in the United States and abroad. TASH affirms that

quality of life, respect and dignity are basic human values that apply to all people, and should not be denied on the basis of stigmatizing discrimination.

National Spinal Cord Injury Association, Inc. (hereinafter "NSCIA") is the largest civilian organization in the United States dedicated to improving the quality of life of persons disabled by spinal cord injury. Its members are among the more than 250,000 Americans paralyzed as a result of injury and disease to the spinal cord. Thus, NSCIA has a unique, real world perspective on some of the core misconceptions about severe disability that have spawned such proposals as Measure 16.

American Foundation for Suicide Prevention is a nonprofit organization dedicated to the prevention and study of suicide. The Foundation was created in 1987 (under its former name of the American Suicide Foundation) by mental health professionals, business and community leaders, and people who had lost loved ones to suicide. The Foundation believes that the legalization of physician-assisted suicide would foster otherwise preventable suicides without improving the care for persons with serious disabilities.

Commission on Aging with Dignity is a Florida-based organization and advocate for older persons. It is committed to promoting positive alternatives to assisted suicide — a "third path" between the dilemmas of "pain or poison" that many older persons fear they will face in the final stages of life. The Commission brings together on a regular basis representatives of government, business, and religion who agree on the need for constructive changes in the current approaches to care provided and made available to older persons.

Michigan Handicappers Caucus (hereinafter "**Caucus**") advocates on behalf of persons with physical and/or cognitive disabilities who reside in Michigan. The majority of its members have permanent disabilities and are indigent; many of the persons it serves are institutionalized and subject to legal guardianship. The Caucus is concerned about the negative

impact that the class-based legalization of assisted suicide will have on persons with disabilities.

National Legal Center for the Medically Dependent and Disabled, Inc., is a non-profit, public interest law firm. The National Legal Center provides legal assistance to persons seeking to obtain or maintain essential medical care and treatment, or who are threatened by stigmatizing policies regarding assisted suicide or euthanasia.

The parties have consented to the filing of this brief. Pursuant to the Rules of this Court, letters of consent from the parties have been filed with the Clerk of the Court.

SUMMARY OF THE ARGUMENT

The Petition for a Writ of Certiorari (hereinafter "Petition") raises an unprecedented question: who has federal standing to challenge assisted suicide laws that are so seriously defective as to implicate numerous federally-protected rights and interests of persons with disabilities? The Petition arises from a challenge against Oregon's Measure 16 brought by, and on behalf of, persons with terminal disabilities (hereinafter "Petitioners").[2] The Petitioners assert that they have standing to challenge Measure 16 because it will inflict stigmatic injury on them if it goes into effect.

The U.S. Court of Appeals for the the Ninth Circuit dismissed the Petition after ruling that the Petitioners lacked Article III standing despite their claim of stigmatic injury. However, this Court and federal appellate courts in other Circuits have determined that stigmatic injury provides sufficient basis for a federal claim cognizable under Article III. The Ninth Circuit's denial of standing suggests either that the Ninth

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[2]Your Amici will not address the issues raised by other parties, such as the physicians and health care facilities suing on their own behalf, and thus any reference to "Petitioners" will include only persons with terminal conditions.

Circuit rejects all stigmatic injury claims as noncognizable, or that it recognizes such claims except when they arise from discrimination based on disability. In either case, the ruling below places the Ninth Circuit in conflict with rulings of this Court and other Circuits.

Moreover, the Ninth Circuit's ruling raises two questions of great public importance. First, should the federal courts employ a double standard under Article III that gives standing, for example, to persons stigmatized by racial or gender-based discrimination, but denies standing to persons stigmatized by disability-based discrimination? Second, should persons with disabilities be precluded as a class from challenging laws that permit assisted suicide, no matter how seriously such laws will injure them?

Supreme Court review is necessary given the nature of the questions at stake, the need to resolve the conflict between the Ninth Circuit decision and other federal precedents, and the case's national importance. The outcome is of enormous significance to persons with disabilities who may suffer stigmatic injuries in any number of circumstances. In the context at hand, this Court's guidance is especially crucial, because it will resolve who has standing to challenge a law that encourages a discrete class, and that class only, to commit assisted suicide. Therefore, the Court should grant the Petition by issuing a writ of certiorari to the Ninth Circuit.

ARGUMENT

I. The Ninth Circuit Ruling Conflicts With The Decisions Of The Supreme Court And Other Federal Courts Of Appeal That Recognize Stigmatic Injury Resulting From Discrimination As A Basis For Article III Standing.

The federal courts have recognized "stigmatic injury" claims, sufficient to confer Article III standing, when a complaint alleges that the aggrieved party is "personally subject to discriminatory treatment" that interferes with a "concrete

interest" (*Allen v. Wright*, 468 U.S. 737, 757 n.22 (1984)), and that such discrimination "perpetuat[es] 'archaic and stereotypic notions' or "stigmatiz[es] members of the disfavored group as 'innately inferior' and therefore as less worthy participants in the political community". *Heckler v. Mathews*, 465 U.S. 728, 739 (1984).

In their Complaint, Petitioners have alleged that: 1) "Measure 16 creates a class of terminally ill persons whom it strips of . . . benefits afforded others [by laws barring assisted suicide, providing for suicide prevention and intervention, and protecting against medical malpactice] " (Third Amended Complaint for Declaratory and Injunctive Relief at 31); 2) "the inadequate safeguards of Ballot Measure 16 increase the vulnerability of [such] persons . . . to request assisted suicide despite their true intent" (*id.* at 8); and 3) ". . . Ballot Measure 16 rests on a judgment that the lives of patients who have the disability of a terminal disease are less deserving of protection than others". *Id.*

Thus, Petitioners adequately alleged stigmatic injuries by asserting that Measure 16 will discriminate against the named patients and the class they represent, as well as the similarly-situated patients of the named physicians and facilities, solely because they have disabilities regarded as terminal. Such discrimination will interfere with their concrete interest in the benefits of being protected by Oregon's ban on assisted suicide, medical malpractice laws, and other suicide prevention or intervention policies, and will stigmatize them as less worthy than others by denying them the same criminal and civil protections against suicide provided to all other Oregonians.

Nevertheless, the Ninth Circuit dismissed the Complaint on standing grounds, and it denied a rehearing petition which asserted that the court had overlooked the Petitioners' stigmatic injury claims. *See* Petition for Rehearing, *reprinted in* Appendix to Petition for a Writ of Certiorari at 78a-80a.

The Ninth Circuit's denial of standing conflicts with the decisions of the Supreme Court and other federal Circuits that

recognize stigmatic injury as a basis for Article III standing to raise civil rights claims. *See* Petition for a Writ of Certiorari at 23-26 and cases cited therein. These cases demonstrate that individuals subject to state policies which invidiously discriminate on the basis of an irrelevant trait, and which stigmatize them as less worthy candidates for a state benefit, suffer a federally cognizable injury.

The denial of standing below indicates either that the Ninth Circuit rejects all stigmatic injury claims regardless of the classification at stake, or that it rejects such claims only when they arise from disability-based discrimination. In other words, by denying standing to Petitioners, the Ninth Circuit may be refusing to acknowledge *any* form of stigmatic injury, thereby rejecting claims brought by *all* persons within the Circuit who suffer such injury; or it may be refusing to acknowledge stigmatic injury claims *only* in cases involving disability-based discrimination.

Therefore, your Amici respectfully request that this Court issue a writ of certiorari to address the conflict caused by the Ninth Circuit's anomalous decision.

II. The Ninth Circuit's Denial Of Standing Raises Significant Questions Of Federal Law That Should Be Addressed By This Court.

The Ninth Circuit's ruling raises at least two issues of great public importance, especially to persons with disabilities, that this Court should address. First, should stigmatic injury claims arising from discrimination based on disability be treated any differently under Article III than stigmatic injury claims arising from discrimination based on race, gender, or other irrelevant characteristics? Second, should persons with disabilities be denied as a matter of course any realistic opportunity to challenge assisted suicide laws such as Measure 16 in the federal courts?

A. *The Ninth Circuit's Ruling Should Be Reviewed Because It Suggests That For Article III Purposes Stigmatic Injury Caused By Disability-Based Discrimination Is Distinguishable From Stigmatic Injury Caused By Racial Or Gender-Based Discrimination.*

If Oregon authorized physicians to provide lethal overdoses only to African- or Asian-Americans or to women — and yet continued to prohibit physicians and every one else from assisting in the suicides of all others — then the stigmatic injury would be undeniably apparent. Federal courts would have no trouble finding that such a policy would perpetuate invidious prejudice and stigmatize racial minorities or women as less deserving of the law's protection against suicide and suicide assistance.

Like all other suspect or quasi-suspect classes, persons with disabilities have historically been subject to "widespread and virulent discrimination" (National Council on Disability, *Position Paper* at 18), and continue to be confronted by "deep-seated" animus. *Id.* at 19. Congress has specifically found that "individuals with disabilities are a discrete and insular minority who have been . . . relegated to a position of political powerlessness in our society . . . based on stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society." ADA, 42 U.S.C. § 12101(a)(7).[3] Thus, their Article III standing to complain of stigmatic injury should not turn on the erroneous assumption that disability-based classifications are any less suspect than those based on race or gender.[4]

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[3]*See also Lake v. Arnold*, No. 96-3412, slip op. at 6-11 (3rd Cir. May 2, 1997) (holding that congressional findings in the ADA's preamble establish that persons with disabilities are a suspect class for purposes of bringing a claim under 42 U.S.C § 1985(3)).

[4]In fact, inequality in legal protection may inflict "immediate, continuing, and real injuries that outrun and belie any legitimate justifications", regardless of whether the classification at stake is

Dr. Carol J. Gill, a clinical psychologist and a nationally recognized expert on the relationship between disability and suicide, testified below to Measure 16's injurious impact:

> [O]ur society increasingly views the support of incurably ill and disabled people as burdensome. This conveys a relentless experience of stigma that can more powerfully erode a person's will to live than can any physical illness. . . . The Oregon Death With Dignity Act will exacerbate this unconscionable trend by . . . setting up a mechanism to distinguish citizens whose death wishes will be overruled from citizens whose death wishes will be validated. It uses health distinctions to determine those who must be protected from despair versus those who can be escorted to its depths.
>
> * * * *
>
> In fact, the very existence of the Act itself is an ominous social validation of suicide for persons with incurable conditions. That public support of the Act comes from a state that has also supported withholding healthcare for certain chronic conditions may be interpreted by many as a message that incurably ill Oregonians are an unwanted hardship for their fellow citizens.
>
> * * * *
>
> In light of the disturbing facts presented above, I submit that the Oregon Death With Dignity Act singles out a class of persons that society is already too quick to discard and further reduces support for and protections of their lives. The

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suspect or not. *Romer v. Evans*, __ U.S. __, 116 S. Ct. 1620, 1629 (1996).

> underlying message is that the life of a person who is incurably ill and predicted to die within six months is not as worthy of support as a physically robust life. That bias is an insidious form of prejudice that disability rights activists call "ableism" or "physicalism." A society that weighs the value of a citizen's life according to health or physical attributes is entering risky territory. When physicians are instructed to adopt such a scale with impunity, the silent and far-reaching effects on health care and on society as a whole will be as impossible to predict as to control. One of the most certain and tragic outcomes, however, is that it will lead to the wrongful premature deaths of persons who, if given basic support and reasonable options instead of a socially and medically sanctioned exit, would prefer to live. It is my professional opinion that the Oregon Death With Dignity Act is dangerously flawed and places at risk thousands of persons with life-threatening disabilities. Further, it removes the safeguards that are in place for all other citizens and thus constitutes a form of codified discrimination against persons with life-threatening disabilities.

Affidavit of Carol J. Gill, Ph.D. at 3-4, 9, 11-12.

As Dr. Gill's testimony makes clear, the stigmatic injuries inflicted by Measure 16 on the Petitioners in this case and similarly-situated Oregonians are just as harmful as any stigma caused by discrimination based on race or gender. The offense is especially grievous because the stigmatizing discrimination encourages members of the affected class to kill themselves.

The National Council on Disability observed that "[f]or many people with disabilities, society has frequently made it clear that it believes they would be better off dead." National Council on Disability, *Position Paper* at 49. Because such attitudes are pervasive, the "quality of life [of people with

disabilities] and [their] worth as human beings have long been egregiously undervalued by society." *Id.* at 11. The Council concluded that laws legalizing assisted suicide would threaten the rights and interests of persons with disabilities precisely because of their stigmatizing effect and their likely role in increasing the risk of mistake and abuse. *Id.* at 49-50.

According to the Council:

> At its core, legalization of physician-assisted suicide would represent a recognition by society that some particular individuals have gotten all the substantial positive benefits they are going to get from their lives, and, in the face of serious pain and suffering they would endure if they continue to live, the few more hours or days they can wring out of existence are not worth it; for such individuals society would be saying that death is preferable to life, and physicians would be empowered to help them terminate their lives. For many people with disabilities, society has frequently made it clear that it believes they would be better off dead, . . . But it is more often the discrimination, prejudice, and barriers that they encounter, and the restrictions and lack of options that this society has imposed, rather than their disabilities or their physical pain, that cause people with disabilities' lives to be unsatisfactory and painful.

Id. at 49.[5]

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[5]In Australia, "a disturbing equation [was regularly] drawn between having 'dignity' and being 'without disability'" in that country's recent debate on assisted suicide. Most public comments submitted to the Parliament that favored assisted suicide associated "undignified" dying with incontinence and immobility. As a result, "the attitude from certain quarters that dying with dignity demands that life ends before such circumstances begin carries a message which only serves to devalue those who live in such circumstances." Senator

Given the similarities between the injuries inflicted by racial, gender-based, or disability-based discrimination, the Ninth Circuit's ruling requires this Court to consider whether the nature of the trait upon which a stigmatizing classification is based should have any bearing on the cognizability of a particular stigmatic injury claim. More specifically, the Ninth Circuit's ruling raises the question: Does it make any legal difference under Article III that Measure 16 discriminates on the basis of disability, rather than, for example, on the basis or race or gender?

Moreover, whether persons with physical and mental disabilities have standing to challenge policies that cause stigmatic injury by incorporating disability-based discrimination is an issue that will arise in a wide variety of circumstances outside the assisted suicide context — including cases alleging discrimination in housing (such as the denial of independent living options), employment, education, and health care services. These cases will involve a host of government programs and benefits, and they will be brought by persons with every form of physical and mental disability. If persons with disabilities cannot complain when they are stigmatized by a law that authorizes doctors to help only them to commit suicide because of their disability, then it is impossible to see how they might bring suit in any of these other circumstances.

Your Amici thus urge this Court to grant the Petition in order to clarify the scope of Article III standing with respect to stigmatic injury claims raised by persons with disabilities.

Eric Abetz et al., *Advice to the Senate* at 11-12, *appended to* Senate Legal and Constitutional Legislation Committee, Australian Parliament, *Euthanasia Laws Bill 1996* (Mar. 1997). A majority of the committee's members drafted *Advice to the Senate* to supplement the official committee report.

B. *The Ninth Circuit Ruling Denies Persons With Disabilities Their Day In Federal Court To Redress A Multitude Of Federal Grievances Against Laws Such As Measure 16.*

While Measure 16 may be the first statute of its kind to be enacted, it will not likely be the last. In 1996, several nearly-identical proposals to legalize assisted suicide were filed in Alaska, Arizona, California, Colorado, Maryland, Massachusetts, Michigan, New Hampshire, New York, South Carolina, Vermont, and Wisconsin. June 1996 Legislation Update at 3-4, *in* Choice in Dying, *Right to Die Law Digest: A Quarterly Review of Legislative Activity and Case Law*. Similar bills have been filed or refiled this year in at least ten states, including Connecticut, Hawaii, Illinois, Maine, Massachusetts, Michigan, Nebraska, Vermont, Washington, and Wisconsin.[6]

These proposals, if adopted, would apply to a broadly defined class of persons with disabilities, and would establish a regime of legalized assisted suicide so irrational and defective as to implicate a broad range of federal violations directly concerning the affected class. This appeal thus raises an additional question of great public importance: Should an entire class of persons with disabilities be effectively denied all opportunity to challenge such proposals in federal court, insofar as they are required to be at the brink of unwanted suicide

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[6]**Connecticut:** H.B. 6083, 1997-98 Leg., 1st Sess. (Conn. 1997); **Hawaii:** H.B.2204, 1997-98 Leg., 1st Sess. (Haw. 1997); **Illinois:** Dignity in Dying Act, H.B. 691, 90th Leg., 1st Sess. (Ill. 1997); **Maine:** An Act to Allow Physician-Assisted Deaths for the Terminally Ill, H.P. 663, 118th Leg., 1st Sess. (Me. 1997); **Massachusetts:** An Act to Regulate Physician Aid in Dying, H.B. 1543, 180th Leg., 1st Sess. (Mass. 1997); **Michigan:** S.B. 81, 89th Leg., 1st Sess. (Mich. 1997); **Nebraska:** Physician Aid-In-Dying Act, L.B. 406, 95th Leg., 1st Sess. (Neb. 1997); **Vermont:** An Act Relating to Rights of Terminally Ill Patients, H. 109, 64th Leg., 1st Sess. (Vt. 1997); **Washington:** S.B. 5654, 55th Leg., 1st Sess. (Wash. 1997); **Wisconsin:** Death with Dignity Act, A.B. 32, 93rd Leg., 1st Sess. (Wis. 1997).

before such challenges could be brought?

Ostensibly, the proposals to legalize assisted suicide apply only to persons with "terminal conditions". Like Measure 16, however, most of them define what constitutes such a condition in the broadest of terms. Measure 16 applies to persons with "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months." Section 1.01 (12). Similarly, the 1997 proposals may refer variously to "an affliction that is likely to result in the individual's death within six months" (Massachusetts), "an incurable or irreversible condition which will result . . . in . . . death within six months" (Maine & Nebraska), and "an incurable and irreversible disease that has been diagnosed by an individual's attending physician and medically confirmed and that will, within reasonable medical judgment, cause death within 6 months" (Wisconsin). One proposal expands the meaning of "terminal" even further by including conditions that will result in death "within one year" (Vermont).

These definitions would encompass many, if not most, forms of serious disabilities. For example, any person with an "incurable and irreversible" disability — such as paraplegia, quadriplegia, severe mental retardation or serious head injury — who requires medical attention or assisted living services to meet basic survival needs, and who will die without such support within the designated time, would be regarded as terminal. Thus, these proposals will directly affect the rights and interests of a considerable number of persons with disabilities.

Moreover, apart from their classificatory scheme, all of these proposals are facially vulnerable to challenge on other federal grounds because they institute grossly inadequate policies and safeguards against mistake and abuse. *See, e.g.*, Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Richmond L. Rev. 1 (1996) (criticizing similar proposals introduced in twelve states in 1995). Given the irremediable

and lethal nature of the risks created thereby, those directly affected should not have to wait until the threats are realized before their federal grievances can be heard.[7]

Yet, by denying standing to the Petitioners in this case, the Ninth Circuit has signalled that the federal courts will not be accessible to complaints against such laws unless a person with disabilities is on the brink of unwanted suicide. Limiting standing to sue to such exigent circumstances will, as a practical matter, make any prophylactic federal relief extremely difficult if not impossible to obtain. Thus, in effect, the Ninth Circuit's ruling immunizes Measure 16-type laws from remedial federal challenge no matter how irrational they are in their conception and design, and no matter how serious and inevitable are the risks they create.

In sum, the Ninth Circuit's ruling is of obvious constitutional importance because it denies an entire class of persons with disabilities their day in federal court and insulates an entire class of seriously defective laws from effective federal scrutiny.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

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[7]Even a law which contains every safeguard imaginable will fail to extinguish the stigma caused by singling out persons with disabilities as the only appropriate candidates for death, and such a law may still fail in its application to eliminate the risks of mistake and abuse. For example, in the Netherlands "[v]irtually every guideline [for assisted suicide] set up by the Dutch — a voluntary, well-considered, persistent request; intolerable suffering that cannot be relieved; consultation; and reporting of cases — has failed to protect patients or has been modified or violated." Herbert Hendin et al., *Physician-Assisted Suicide and Euthanasia in the Netherlands: Lessons From the Dutch*, 277 J.A.M.A. 1720, 1722 (1997).

Respectfully submitted,

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Filed June 16, 1997

This Brief was written with the support of funds provided by the Alliance Defense Fund.

Supreme Court U.S.
FILED
AUG 28 1997
CLERK

(H)

No. 96-1824

In the Supreme Court of the United States

OCTOBER TERM, 1996

GARY LEE, M.D., individually and on behalf of his terminally ill patients; WILLIAM PETTY, M.D., individually and on behalf of his terminally ill patients; JANICE ELSNER, individually and as representative of a class of terminally ill patients; et al.,

Petitioners,

v.

F. DOUGLASS HARCLEROAD, et al.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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28 pp

QUESTION PRESENTED

Whether the facts in this record establish that plaintiffs personally will suffer an imminent, concrete, and non-speculative injury sufficient to give them standing to challenge Oregon's Death With Dignity law.

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STATEMENT OF THE CASE

The questions presented in the petition for certiorari raise three issues, all of which involve whether specific plaintiffs have standing. Neither the allegations of the complaint nor the specific facts relevant to standing are set forth in the petition's statement of the case, however. Although the statement of the case provides some facts relevant to one named plaintiff (Janice Elsner), it does so only in conclusory and argumentative terms. Pet. Cert. 2. The State therefore offers the following description of the complaint and the specific facts produced by affidavit or deposition that are important to the standing issues presented. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992) (as trial proceeds beyond pleading stages, a plaintiff can no longer rest on generalized allegations of injury, but must produce "specific facts" to support standing).

I. Plaintiffs' Legal Theories

Plaintiffs filed a class action complaint alleging that Oregon's Death With Dignity Act ("Measure 16" or "the Act") violates various constitutional provisions, primarily the Equal Protection and Due Process Clauses of the federal constitution, as well as certain rights secured by federal statute.[1] The complaint set forth allegations for three categories of plaintiffs: persons suffering from debilitating or terminal illnesses; physicians; and nursing or other care facilities. The thrust of the complaint was that Measure 16 is unconstitutional because it lacks adequate safeguards to ensure that a terminally ill person's decision to obtain a lethal prescription will be competently and voluntarily made. *See generally* Third Amended Complaint for Declaratory and

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[1] Specifically, the plaintiffs alleged violations of equal protection and due process under the Fourteenth Amendment; free exercise, speech and association under the First Amendment; the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 1201 *et seq.*; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §§ 791 *et seq.*; and the Religious Freedom Restoration Act of 1993, 42 U.S.C. §§ 2000bb *et seq.*

Injunctive Relief. The medical and care professionals also alleged that the measure would force them to act contrary to their religious or associational interests. Complaint, ¶¶ 4–5, 10–13.

In particular, the complaint alleged that inadequate safeguards exist to protect patients from undue influence, coercion, depression, mental and/or emotional disability in making the decision whether to seek physician assistance in dying. Complaint, ¶¶ 45–51. The allegations culminated in the assertion that Oregon has "an obligation * * * to provide safeguards assuring voluntariness commensurate with the risk involved to its citizens." Complaint, ¶ 52. The complaint then set forth in five counts the particular constitutional and statutory violations that plaintiffs claimed Oregon's Death With Dignity Act violated. Complaint, pp. 32–39.

II. Janice Elsner

Only one of the individual patient plaintiffs, Janice Elsner, remains in the case.[2] As to her, the full text of the allegations in the complaint were as follows:

> Plaintiff Janice Elsner is a person with progressive muscular dystrophy who uses a wheelchair. She is a resident of Portland, Oregon. She is 46 years old and has had periods where she is so weak that she is limited to a liquid diet because she is too tired to eat. At such times, she can't turn over in bed. She does not know how long she has to live, but has already lived longer than expected. She has problems with depression as a result of her condition and understands that depression may go undiagnosed and causes some to consider suicide. She

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[2] The district court found standing for only two of four patient plaintiffs, Eric Dotson and Janice Elsner. Pet. Cert. App. 59a–61a. Eric Dotson later died of AIDS. Petitioners did not cross-appeal the denial of standing to the other two patient plaintiffs. Therefore, Janice Elsner is the only remaining patient plaintiff and potential class representative.

> would never want to consider assisted suicide but understands that persons who have the disability of a terminal disease are sometimes subject to undiagnosed depression or undue influence while in a debilitated state and become persuaded to act contrary to their true intent, which she would never want to happen to her. She believes the inadequate safeguards of Ballot Measure 16 increase the vulnerability of persons like herself to request assisted suicide despite their true intent. She brings this suit on her own behalf and as a co-representative of a class of persons who have the disability of a terminal disease even with medical treatment.

Complaint, ¶ 7.

In response to the defendants' motions for summary judgment, plaintiffs submitted Janice Elsner's affidavit. Pl. Supp. Stmt. of Material Facts. The affidavit established that Ms Elsner, who is a mother and a homemaker, has suffered from muscular dystrophy since the age of eight. (Elsner Aff., at 1). For a couple of months during the last three years, the physical exhaustion caused by her condition became particularly extreme and, contrary to her usual "very cheerful and optimistic" nature, she became depressed. (*Id.*, at 2).

Ms Elsner averred that she "understands" that depression may go undiagnosed and "causes some to consider suicide." Similarly, she "understands" that terminally ill persons are "sometimes subject to undiagnosed depression or undue influence" and "become persuaded to act contrary to their true intent." (*Ibid*). As to her own possible suicidal tendencies, however, nothing in her affidavit states or implies that she has ever considered actively taking her own life. Instead, she said only: "Though I would never choose assisted suicide willingly, I cannot foresee how I will feel under circumstances which I have not yet experienced." (*Ibid*).

Defendants deposed Ms Elsner and submitted relevant portions of that affidavit to the district court in support of their motion for summary judgment. *See* Def. Supp. Stmt. of Material Facts. Ms Elsner confirmed that she does not know how long she will live, but she acknowledged that no doctor has advised her that she has only a short time to live or has given her any other estimate of time. (Elsner Depo., at 13–14, 20). Her medical condition is such that she could live another five to ten years, or only a short time longer. (*Id.*, at 20). Her doctors "stay pretty hopeful" about her condition, however. (*Ibid*).

On the subject of depression, Ms Elsner elaborated on her statement in her affidavit that she has problems with depression. She explained that she has been diagnosed as depressed only once. (*Id.*, at 20). That occurred a couple of years ago when, in the course of an unrelated and prescheduled appointment, Ms Elsner's emotional condition caused her doctor to be concerned about possible depression and to refer her to a mental health professional. (*Id.*, at 39–40). She was diagnosed as depressed and treated by a psychologist. The treatment did not require medication. (*Ibid*). The referral to the psychologist was made by Ms Elsner's regular doctor and was the doctor's idea, not hers. (*Id.*, at 40). Although she has not been diagnosed as depressed before or since then, (*Id.*, at 20), she believes she in fact has been depressed at other times when her health has been particularly bad. (*Id.*, at 14). At the time of the lawsuit, she was not depressed. (*Id.*, at 20).

Ms Elsner did not describe herself as ever having contemplated killing herself under any circumstance. At most, she once expressed some ambivalence about whether she wanted to continue living. When her doctor became concerned about her emotional condition and referred her to a psychologist, he asked her whether she wanted to live. She told him "I don't know. I

don't think so," or something to that effect. (*Id.*, at 39). She did not suggest that she has ever considered actively taking her own life, however. Nor has she ever asked a physician for help in taking her life. (*Ibid*). To the contrary, Ms Elsner stated that she would not request a lethal prescription as authorized by Measure 16. (*Id.*, at 32). When asked if she thinks that "in the future something could happen" that would change her mind, she answered "You never know. Probably not, no." (*Ibid*). When asked a second time if she could foresee any scenario in which she might end up choosing or requesting assisted suicide, her answer was:

> It's easy to say no. I mean, I would never consider it or anything, but when I was really sick, and if I remember that time correctly, it was a hell of a time, and you lay there and it's really hard to think and you get really depressed. And because you need so much care, you feel like you're imposing on too many people for too many days and it—and I think sometimes in your deep depression you could probably just say "I want to give it up." *But I don't foresee myself doing that.*

(*Id.*, at 37) (emphasis added).

Nor did Ms Elsner believe that undue influence or coercion might cause her to invoke the choices available under Measure 16. Her family knows of her opposition to physician-assisted suicide and supports her in her efforts to oppose it. (*Id.*, at 11). She has talked to her doctor about her involvement in the litigation opposing Measure 16. (*Id.*, at 32). She is not aware of anyone—family, friends, health care providers, or others—whom she believes might try to coerce her to obtain physician assistance under Measure 16 to end her own life. (*Id.*, at 29). If she were without medical insurance, she might be concerned that financial hardship might be a factor. But her medical expenses are paid through Medicaid, a tax-supported program, and she has

no reason to worry that her health care benefits will be cut off. (*Id.*, at 10–11, 38).

Ms Elsner stated explicitly that she could not identify any injury she has suffered due to Measure 16. (*Id.*, at 34). She is involved in the litigation for the same reasons that she opposed Measure 16 during the campaign in Oregon. Her efforts as a plaintiff are a continuation of her earlier effort to defeat the measure. (*Id.*, at 25–26). She would oppose any form of law that would provide physician assistance in dying for the terminally ill, even one containing stronger safeguards. (*Id.*, at 15).

III. Physicians and Care Facilities

Dr. Gary Lee alleged that Measure 16 contains inadequate safeguards to protect patients from seeking physician assistance in dying due to depression or undue influence. He claimed standing to assert:

> the rights of his patients who have the disability of a terminal disease who do not wish to engage in assisted suicide but may be subject to internal and external pressures toward assisted suicide which they may be unable to resist given the lack of appropriate safeguards.

Complaint, ¶ 4. He also objected "on moral grounds" to being required to advise patients of their rights under Measure 16 and having to transfer patient records to other physicians who would assist patients under the Act. *Ibid.* Dr. William Petty's allegations were substantially identical, except he based his objections on religious as well as moral grounds. Complaint, ¶ 5.

Similarly, various care facilities and nursing homes objected on free speech and freedom of religion grounds to having physicians on staff who might opt to assist patients under the Act, or having to associate in other ways with individuals (*e.g.*, witnesses) who might be involved in a patient's decision to seek a lethal

prescription from a physician. Complaint, ¶¶ 11, 12, 13. In an allegation identical to that of Drs. Lee and Petty, two of the three care facilities asserted the rights of terminally ill patients who do not want a physician to assist them in dying, but who might opt for a lethal prescription because the Act contains inadequate safeguards to protect them from coercion and influence. Complaint, ¶¶ 11, 13.

REASONS TO DENY THE WRIT

I. Introduction

On November 8, 1994, Oregon voters enacted the Death With Dignity Act (Measure 16), which had been placed on the ballot through the State's initiative process. Measure 16 establishes a statutory framework within which a competent terminally ill adult legally may request a prescription for medication "for the purpose of ending his or her life in a humane and dignified manner." Measure 16, § 2.01, Pet. Cert. App. 22a. With that enactment, Oregon became the first State in history to give recognition to the often compelling concerns of competent terminally ill adults who seek to meet death in a manner that reflects their values and preserves their personal dignity.[3]

Petitioners seek to heighten the Court's interest in this case by emphasizing the historical significance of Oregon's law and

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[3] Those concerns are undeniably compelling in human terms, and perhaps in some circumstances, constitutional ones as well. The majority opinion in *Washington v. Glucksberg* explicitly stated that, in declining to announce a general due process right to physician-assisted death, it was not foreclosing the possibility that such a right might be acknowledged in individual circumstances. ___ U.S. ___, 117 S.Ct. 2258, 2275, n. 24 (1997). Several of the concurring opinions suggest more strongly that on different facts, some members of the Court might find constitutional protection for individual autonomy in avoiding excessive pain and in controlling the timing and manner of death. *E.g.*, O'Connor, J., 117 S.Ct., at 2302–03 (concurring); Stevens, J., 117 S.Ct., at 2304–05 and 2310 (concurring in the judgment).

by inviting the Court to proceed all but directly to the merits of their challenges. *See, e.g,* Pet. Cert. 7–10. The only issue before the Court, however, is standing: Standing was the only issue decided by the court of appeals and the only issue framed by the questions presented and briefed in the petition for certiorari. Sup. Ct. Rule 14(1) (issues before the Court are limited to the questions presented). As the Court has on other occasions, it "must put aside the natural urge to proceed directly to the merits of this important dispute and to 'settle' it for the sake of convenience and efficiency." *Raines v. Byrd*, ___ U.S. ___, 117 S.Ct. 2312, 2317 (1997) (standing to challenge Line Item Veto Act). Standing, as a jurisdictional requirement and constitutional imperative, cannot be waived, bypassed, or decided in favor of plaintiffs for the sake of expediency. *See generally ibid*; *Allen v. Wright*, 468 U.S. 737, 750–53 (1983).

The case does not warrant a grant of certiorari. The standing issue at most presents questions that turn on the application of settled law to these particular facts. Moreover, the court of appeals decided the case correctly, so review would not alter the outcome. Finally, review would serve only to unnecessarily delay the case, and in doing so, to forestall implementation of Oregon's law or final resolution of whatever constitutional challenges may be brought by proper plaintiffs.

II. The Standing Issue in this Case Does Not Warrant Certiorari Review.

A. This Case Involves Only a Fact-Specific Application of Settled Legal Principles.

One of the "bedrock requirements" of Article III, section 2 of the Constitution is that federal courts have jurisdiction only over "cases" or "controversies." *Valley Forge Christian College v. Americans United for Separation of Church and State, Inc.*,

454 U.S. 464, 471 (1982). A key element of the case-or-controversy requirement is that a plaintiff, based on the complaint, must establish standing to sue. *Lujan v. Defenders of Wildlife*, 504 U.S., at 561 (plaintiffs bear burden of establishing standing).

The Court has "consistently stressed" that to satisfy the standing inquiry a plaintiff must establish that a "personal stake" in the alleged dispute in the form of an injury that is personal to the plaintiff. *Raines v. Byrd*, 117 S.Ct., at 2317 (citing cases). The "injury in fact" requirement is an exacting one: the harm must be concrete and particularized, actual or imminent, and not "conjectural" or "hypothetical." *Lujan v. Defenders of Wildlife*, 504 U.S., at 560 (citing cases). Moreover, there must be a distinct causal connection between the injury and the conduct complained of—that is, the injury must be "fairly * * * traceable to the challenged action of the defendant, and not the result of the independent action of some third party not before the court." *Ibid.* Finally, it must be "likely" and not merely "speculative" that the injury will be redressed by a favorable decision. *Ibid.* Those requirements reinforce a fundamental concept that underlies the standing doctrine: the federal judiciary is not the appropriate forum to address generalized complaints that primarily reflect moral or philosophical disagreement with the law; rather, a court's role is to adjudicate specific legal rights and obligations as between parties who have a direct stake in the outcome of the adjudication. *See Allen v. Wright*, 468 U.S., at 760–61.

The Ninth Circuit, in concluding that plaintiffs lack standing, looked to the settled jurisprudence of this Court. Pet. Cert. App. 8a–16a. The court of appeals' focus was on whether plaintiffs had demonstrated that they had suffered any injury-in-fact. Specifically, the court of appeals scrutinized plaintiffs' claims to

determine whether the injuries that plaintiffs claimed they would suffer were real, concrete, and imminent or, alternatively, whether they were remote, speculative, or unlikely. *Ibid.* Although that inquiry alone defeated plaintiffs' claims, the court also expressed doubts about whether there was adequate causal connection between the injury and the conduct complained of, and whether the injury would be redressed by a favorable decision. *Id.*, at 15a–16a and nn. 3, 4.

Plaintiffs' disagreement with the decision below is essentially a quarrel with the result, not with the applicable law.[4] As plaintiffs' arguments in the petition generally suggest, and as they state explicitly at one point, they frame their standing arguments within "the mainstream of conventional standing law." Pet. Cert. 23. To be sure, plaintiffs may dispute whether the court of appeals was faithful to the controlling principles, just as the State questions whether plaintiffs' arguments are faithful to the stringent requirements of the Court's settled jurisprudence. But that, too, is a dispute directed to the correctness of the result rather than to the principles that guide the inquiry.

Thus, this is a case that turns on its facts. It presents the Court only with a question of whether established standing principles were correctly applied to this record. A grant of review would not resolve any significant conflict among lower

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[4] Plaintiffs and their amici's insistence on characterizing this as a claim of "stigmatic injury" adds nothing of significance to the analysis. *See* Pet. Cert. 23; Am. Disabled et al. Am. Br. 8–10. A claim of stigmatic injury, too, requires a demonstrated injury-in-fact in the form of some concrete interest that has been directly invaded. *Allen v. Wright*, 468 U.S., at 756, n. 22. As the Court has observed, if abstract stigmatic injury were cognizable, standing would become automatic for any member of a generalized group interested in a law or its application, not just injured members of the group. *Id.*, at 756. That in turn would transform the federal courts into "no more than a vehicle for the vindication of the value interests" of concerned citizens, a result that Article III precludes. *Ibid* (citation omitted).

courts.[5] Review would not clarify any important area of law that is confused or in disarray. Nor do plaintiffs seek to have the Court recognize some new principle of standing. In short, the petition merely invites the Court to correct a perceived error; it presents no issue of importance beyond the resolution of this particular standing dispute. That is not the kind of compelling basis on which the Court traditionally does, or in this case should, exercise its certiorari jurisdiction. *See* Sup. Ct. Rule 10.

B. The Ninth Circuit Resolved the Standing Inquiry Correctly.

Even were this Court to grant certiorari to review this fact-specific issue, that review would not change the outcome. The Ninth Circuit correctly determined that the remaining patient (Janice Elsner), physicians (Drs. Lee and Petty), and care facility plaintiffs failed to demonstrate a sufficient injury-in-fact to confer standing.

1. Janice Elsner

Plaintiffs argue that Janice Elsner has standing for two reasons. First and foremost, they claim Elsner will suffer a *future* injury because she has an established history of "recurring bouts of suicidal depression" that create an "imminent and substantial risk" that she will end her own life using the physician assistance available under Measure 16, against her true desire to continue living. Pet. Cert. 2, 16–22. Second, petitioners assert a *present* injury, the "essence" of which "lies in the unequal treatment that denies them the same benefits of the

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[5] The only "conflict" petitioners point to is one inherent in standing analysis —that is, different results arising from the application of settled analysis to different fact patterns. *See Allen v. Wright*, 468 U.S., at 751–52 (because standing concepts have gained considerable definition, the standing inquiry in many cases can be answered chiefly by comparing the allegations of a particular complaint to those made in prior standing cases).

homicide code and civil protections provided to non-terminally ill individuals." Pet. Cert. 25. This injury, they maintain, will be inflicted "the moment that Measure 16 becomes law." *Ibid.*

a. Terminal Illness

The first problem with Ms Elsner's standing is fundamental and eclipses the several other defects in her claims of future and present injury: she has neither alleged nor demonstrated through specific proofs that she is terminally ill. Thus, she has not even demonstrated that she falls within the class of citizens subject to Measure 16 procedures.[6]

Measure 16, in unequivocal terms, defines "terminal disease" to mean "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months." Section 1.01 (12), Pet. Cert. App. 22a. No physician has diagnosed Ms Elsner as having less than six months to live. There is no suggestion that any physician, within reasonable medical judgment, could do so. To the contrary, Ms Elsner was explicit in describing her condition as one in which that diagnosis *cannot* be made—she might live only a short time, but she is just as likely to live five or ten years more. Her doctors remain "pretty

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[6] That is not to say that someone who is not terminally ill might not have standing to bring some form of challenge to Measure 16. Indeed, perhaps the more foreseeable challenge to this law would be by individuals who are not terminally ill within the statute's definition, but who have compelling personal reasons (*e.g*, permanent incapacity and severe pain) to end their own lives with physician aid. Such an individual likely would have standing to assert an equal protection claim on the theory that the law irrationally limits the "benefited class" to persons diagnosed as having less than six months to live. Whether that challenge would prevail, of course, is an open question. As the several opinions in *Glucksberg* suggest, narrowly proscribing availability of physician assistance in dying is a rational if not compelling means for States to further their interest in preventing abuse of the procedure. *See*, *e.g.*, *id.*, 117 S.Ct., at 2291 (Souter, J.) ("The case for the slippery slope is fairly made out here * * * because there is a plausible case that the right claimed would not be readily containable").

hopeful" about her prognosis. That is not a "terminal" condition within the meaning of Measure 16, plain and simple.

The court of appeals' willingness to "assume" that Ms Elsner has a terminal disease and to focus on the speculative nature of the injury is understandable, because the opinion served to provide potential plaintiffs with far more guidance about what would be required, even for someone given a prognosis of less than six months to live.[7] The district court's willingness to look past that flaw in standing is perplexing, but it is consistent with the generous view the trial court took of plaintiffs' standing generally. *See* Pet. Cert. 57a–62a. In any event, were this Court to grant review, the fact that Ms Elsner has not been shown to have a terminal illness would be insurmountable and would preclude going any further in the case.

b. Future Injury

The court of appeals, while simultaneously noting its doubts about whether Ms Elsner is terminally ill, ultimately rejected her claim of future injury as built upon a "chain of speculative

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[7] Specifically, the court stated: "Although she has not been given a prognosis of less than six months to live, for purposes of analysis we will assume that she has a terminal disease within the meaning of Measure 16." *Lee v. State of Oregon*, Pet. Cert. 10a. Later, in analyzing physician standing, the court explained the reason for its assumption:

> We note that Elsner may not in fact have a "terminal disease" as defined in Measure 16, and may therefore not be able to invoke Measure 16's provisions in the first instance. However, precisely because of the possibility that the named doctors and residential care facilities could assert the interests of their terminally-ill patients, we assume that Elsner does have a "terminal disease" for purposes of the "injury in fact" analysis.

Id., Pet. Cert. 15a, n. 3. Thus, the court recognized that where the physician plaintiffs were concerned, other terminally ill patients undoubtedly were involved. The court reasonably focused on its concerns about the unduly speculative nature of Ms Elsner's injury so that the plaintiffs would understand that even patients who could demonstrate the necessary prognosis would have to be "closer to suffering the asserted injury than Elsner." *Id.*, Pet. Cert. 15a.

contingencies." Pet. Cert., at 11a. Plaintiffs dispute that conclusion, attempting to refute each link in the court's chain. For present purposes, rather than debate plaintiffs' argument point by point, the State is content to rely on the court of appeals' discussion, because it is persuasive. A few added points about the record and the court of appeals' conclusion can be profitably highlighted, however.

First, in their petition, plaintiffs never meet the court of appeals' concern that Ms Elsner's claim of future injury rested all but entirely on assertions drawn from "empirical facts" about terminally ill persons in general. Specifically, plaintiffs' argument essentially is that terminally ill adults generally tend to suffer from depression; that such depression generally tends to impair their decision-making; that treating physicians generally have difficulty diagnosing depression; and that when terminally ill individuals are treated for depression and pain, they generally change their minds about wanting to die. In short, Ms Elsner's claim of injury was built more on allegations about the class she sought to represent than on her own circumstances.

As the court below observed, however, Ms Elsner's claim of future injury must be *individualized* as to her. *Lee v. Oregon*, Pet. Cert. 12a. She *personally* must be able to claim that she will imminently suffer the injury alleged. That is no less true for a class action than for other suits. "That a suit may be a class action, * * * adds nothing to the question of standing, for even named plaintiffs who represent a class 'must allege and show that they personally have been injured, not that injury has been suffered by other, unidentified members of the class to which they belong and which they purport to represent.'" *Simon v. Eastern Ky. Welfare Rights Organization*, 426 U.S. 26, 40 n. 20 (1976) quoting *Warth v. Seldin*, 422 U.S. 490, 502 (1975). Plaintiffs continue to rely on generalized evidence about termi-

nally ill persons, rather than Ms Elsner's individualized circumstances. *See generally* Pet. Cert. 13–16. To the extent they do, their claim of standing must fail.

As to the *individualized* demonstration of Ms Elsner's standing, the court of appeals was gentle-handed with what were completely inadequate proofs. No credible argument can be made on this record that Ms Elsner is imminently in danger of suicidal depression or undue influence that would cause her to obtain a lethal prescription under Measure 16. One simple fact defeats it: Ms Elsner's own testimony that she could not foresee herself seeking a physician-assisted death under any scenario. She could envision facts that hypothetically might cause a person to want to make that choice. But she candidly acknowledged that her philosophical opposition to doing so is so strong that it was not a decision she thought she would ever make.

That testimony, in and of itself, forecloses her claim of standing. But the record is defective in other ways, as well. Ms Elsner's family is fully aware of her opposition to suicide under any circumstance and supports her efforts to defeat Measure 16. Her treating physician has proven capable of recognizing her depression, even if other physicians might not. Moreover, her physician knows of her opposition to Measure 16. It is only reasonable to conclude that Ms Elsner's family and physician would be highly suspect of any request she would make for a lethal prescription and they would not readily comply with it without forcing some form of consultation with a mental health professional. Of course, that is not certain. But plaintiffs' claim requires the Court to try to anticipate future events. In so speculating, the far more likely scenario in Ms Elsner's individual case is that she would be surrounded by friends, family and physicians who all would recognize something was amiss if *she*, of all people, made such a request. Indeed, in her particular case

and on this record, such intervention seems nearly certain. And while one could wonder whether Ms Elsner might discharge her current doctor, or might find a way to guard family and friends from the knowledge that she was asking for a lethal prescription, such speculation goes far beyond anything this record suggests.

In short, Ms Elsner's factual showing of standing is not only weak, but it is affirmatively refuted by her own statements. The court of appeals, rather than seizing on that problem, addressed the aspects of her claim that are more typical of the class she sought to represent in general, perhaps so that plaintiffs would understand the hurdles they would face even with other potential class representatives.

The fact is, for someone not yet suicidal, not yet clinically depressed, not yet asking for a lethal prescription, and for whom the safeguards have not yet proven inadequate, it is difficult to show an "imminent" likelihood of the injury plaintiffs seek to redress. The problem is compounded by the fact that the claimed injury requires a series of cumulative failures—that is, a failure of physician judgment, *and* of witness judgment, *and* of waiting periods to result in a change of mind or mental state, *and* of notification to family, *and* of concerned family or friends to intervene, among others. As this Court has pointed out, standing is inherently difficult to show when the claimed injury is caused by government regulation or nonregulation of third parties:

> When * * * as in this case, a plaintiff's asserted injury arises from the government's allegedly unlawful regulation (or lack of regulation) of someone else, much more is needed [than when plaintiff is a direct object of government action or inaction]. In that circumstance, causation and redressability ordinarily hinge on the response of the regulated (or regulable) third party to the government action or inaction—and perhaps on the

> response of others as well. The existence of one of the essential elements of standing "depends on the unfettered choices made by independent actors not before the courts and whose exercise of broad and legitimate discretion the courts cannot presume either to control or predict" and it becomes the burden of the plaintiff to adduce facts showing that those choices have been or will be made in such manner as to produce causation and permit redressability of injury. Thus, when the plaintiff is not himself the object of the government action or inaction he challenges, standing is not precluded, but it is ordinarily "substantially more difficult" to establish.

Lujan v. Defenders of Wildlife, 504 U.S., at 561.

In effect, plaintiffs undertook to show here that imminent injury-in-fact will befall them because the State does not *sufficiently* regulate this personal choice and the professionals involved in it. The injury they complain of is not a direct consequence of decisions government makes or actions government takes. Instead, it follows from the personal choices of plaintiffs, the professional judgments of physicians, the observations of witnesses, the interest and attentiveness of family and friends, and myriad other factors. Plaintiffs' obligation, therefore, was to show that those choices, misjudgments, and errors have been made, or with high likelihood, imminently will be made. And as the court of appeals recognized, because the injury depends not just on a single choice and misjudgment, but on a full and unbroken sequence of them, the showing they must make becomes significantly more difficult. That is not a basis for objection, however. Instead, it is the heavy burden plaintiffs assumed in bringing this lawsuit on the theories they alleged. The specific factual evidence relevant to Ms Elsner's standing simply did not satisfy that burden.

c. Present Injury

The second prong of plaintiffs' argument in their petition is that Ms Elsner suffers a present injury. The argument is that the moment Measure 16 takes effect, she stands *presently* stripped of the civil and criminal protections available to the non-terminally ill, and she thus suffers a present injury-in-fact. Pet. Cert. 22. That argument fails as a matter of law and on the pleadings and proof.

First, as a matter of law, Measure 16's mere enactment does not work any immediate and present change of legal status or position for any terminally ill adult. Terminally ill adults are protected by civil commitment and criminal laws to the same extent as non-terminally ill adults unless and until they obtain a lethal prescription by following all of the special procedures that Measure 16 requires. That is, a terminally ill adult is in a position identical to that of a non-terminally ill adult *unless* the terminally ill person first makes the choice to have physician assistance in dying and then goes through the full series of steps required by Measure 16's terms.[8] No terminally ill person, upon

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[8] Measure 16 contains detailed requirements for obtaining physician assistance in dying. *See generally* Pet. Cert. 20a–34a. The Act does not require physicians to honor patient requests for assistance in dying. If a physician chooses to do so, however, upon a proper patient request, a physician can write the requested prescription and avoid civil and criminal liability if she acts in accordance with the safeguards set forth in section 3 of the Act. The safeguards include: (1) an initial determination by the attending physician that the patient has a terminal disease, is capable, and has made the request voluntarily; (2) disclosure by the attending physician to the patient of the medical diagnosis, prognosis, risks, probable result, and any feasible alternatives; (3) confirmation by a second physician of the diagnosis and the fact that the patient is capable and acting voluntarily; (4) counseling whenever the attending physician or consulting physician suspects that the patient may be suffering from a psychological disorder or depression causing impaired judgment; (5) family notification (at the option of the patient); (6) a requirement that the patient make at least two oral requests and one written request; (7) a fifteen-day waiting period between the initial request

(continued...)

Measure 16's enactment, stands presently "stripped" of anything. As a matter of law, until Ms Elsner invokes the choice that Measure 16 makes available to terminally ill persons and follows the procedures that Measure 16 requires, her legal position is unchanged.

Second, as a matter of pleading and proof, this injury is not alleged in the complaint or established in the record. The standing inquiry requires "careful judicial examination of a complaint's allegations to ascertain whether the particular plaintiff is entitled to an adjudication of the particular claims asserted." *Allen v. Wright*, 468 U.S., at 752. The gravamen of the complaint here is that Ms Elsner will suffer an imminent and substantial future injury in the form of an unwanted death, due to Measure 16's inadequate safeguards. No present injury is alleged. Nor did the more specific factual evidence produced through Ms Elsner's affidavit and deposition remotely suggest that she suffers this "present" injury; indeed, she explicitly denied that she does. *See*, *infra*, at p. 5.

2. Physician/Health Care Providers

Plaintiffs make several arguments as to why the Ninth Circuit was wrong in concluding that the physician and health care providers lack standing in this case. Those arguments are without merit.

1. As plaintiffs recognize, to the extent that the physician and other health care providers attempted to invoke the standing of their terminally ill patients who would be in the class represented by Ms Elsner, their standing at a minimum succeeds or fails with Ms Elsner's standing. Because Ms Elsner lacks standing, the

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[8](...continued)

and the writing of the prescription; and (8) a right to rescind the request at any time regardless of the patient's mental state.

physician and health care providers cannot assert standing to represent the interests of their patients in the class.

2. The court of appeals recognized that the physicians' and heath care providers' claims went beyond asserting the rights of their terminally ill patients. Rather, they included allegations that Measure 16 violates protected speech, religion, and association interests of the providers by requiring them to advise patients of their choices under Measure 16, to associate with physicians who are willing to provide prescriptions under the Act, and/or to transfer patient records to physicians who are so willing. *Lee v. Oregon*, Pet. Cert. 17a. The Ninth Circuit correctly concluded that those claims suffer from both ripeness and standing problems.

As the Ninth Circuit held: "Measure 16 does not provide for any penalty, criminal or otherwise, for a violation of the challenged provisions." *Id.*, Pet. Cert. 18a. Rather, the Act imposes criminal sanctions only for forging a request for a lethal prescription and for coercing a patient to make a request for life-ending medication. Measure 16, § 4.02; Pet. Cert. 31a. The Ninth Circuit held that without any penalty for failing to provide information to patients and refusing to transfer records or to facilitate patient choice in other ways, there was no concrete and particularized injury to the health care providers. *Ibid.*

Plaintiffs disagree with that conclusion only factually. They point to section 4.02(4), which provides that the criminal penalties set forth in the Act do not preclude criminal penalties applicable under other laws for conduct inconsistent with the provisions of the Act. The obvious point of that provision is to ensure that penalties for crimes such as murder and assault remain in force if a physician provides a lethal prescription to a patient without complying with the requisite procedures (terminal diagnosis, a properly witnessed request, waiting periods com-

plied with, second physician assessment, et cetera). Plaintiffs' claim might have merit if they could identify some provision in Oregon's criminal code imposing criminal penalties on a physician or health care provider for refusing to transfer a patient's records, refusing to advise the patient of available medical procedures, and so on. Plaintiffs have never alleged that there are any such statutes, nor do they cite any in their argument to this Court. Their claim is without merit.

3. Finally, plaintiffs fault the Ninth Circuit for concluding that any injury the health care providers suffer because of their obligation to advise patients about Measure 16 procedures arises from the informed consent law, not from Measure 16. *Lee v. Oregon*, Pet Cert. App. 17a, n. 6. Plaintiffs argue:

> The panel has ignored the fact that if Measure 16 did not exist there would be no problem, but because it exists these plaintiffs have an imminent, concrete, and particularized injury * * * The panel has confused a cause of action with the imminent injury which gives standing.

Pet. Cert. 29.

It is plaintiffs, not the Ninth Circuit, who are confused. Plaintiffs are not entitled to bring a cause of action directed at an injury related to some other cause of action. As the Court has repeatedly stated, a plaintiff must allege personal injury fairly traceable to the defendant's allegedly unlawful conduct under the challenged law or policy. *See, e.g., Valley Forge Christian College v. Americans United for Separation of Church and State, Inc.*, 454 U.S., at 474–75. In this instance, by plaintiffs' own admission, their alleged injury is directly and fairly traceable to the requirements of the informed consent law, not Measure 16. To remedy that claimed injury, they must bring the appropriate cause of action.

III. Review Would Unnecessarily Delay Final Judgment in the Case.

This Court and the nation already have taken notice of the historically and politically significant enactment that is the object of this litigation.[9] Oregon's Death With Dignity Act is the first American law of its kind, one in which a State's democratic process has adopted a policy of regulating rather than prohibiting physician assistance in some end of life choices. In effect, even in advance of this Court's invitation to do so,[10] Oregon undertook a full public debate on this difficult and emerging issue and chose to provide a solution through the institutional competence of its legislative processes.[11] The solution has never been implemented, however. Oregon's law was enacted nearly three years ago. It has been enjoined by litigation since, without taking effect for so much as one day.

If the State could waive standing requirements and invite the Court to settle the merits, or at least to remand the case promptly to the Ninth Circuit for that purpose, it might do so here. Resolution of the constitutional and statutory challenges plaintiffs have raised would remove the cloud that this litigation has cast over Oregon's Death With Dignity Act. Moreover, if the law

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[9] *See Washington v. Glucksberg*, 117 S.Ct., 2262, n. 7 and 2266, n. 14 (majority); and 2292 (Souter, J. concurring).

[10] The majority and several of the separate concurring opinions in *Glucksberg* extend an express invitation to the States to use their democratic processes to debate the issue of physician assistance in dying for the terminally ill, to examine the evidence through the legislative process, and to devise not only appropriate policies as an outcome of that debate and examination, but to experiment with those policies so that the issue can be better explored both socially and judicially. *Id.*, 117 S.Ct., at 2275 (majority); 2302–03 (O'Connor, J., concurring); 2303 (Stevens, J., concurring); 2292–93 (Souter, J., concurring).

[11] This Court has recognized that the laws generated through the initiative process are subject to the same analysis under federal constitutional provisions as those of representative legislative process. *U.S. Term Limits, Inc. v. Thornton*, 514 U.S. 779, 809, n. 19 (1995).

survives plaintiffs' challenges, as the State believes it will, Oregonians may then have the benefit of the policy they enacted for themselves and their families, and the nation can have the benefit of Oregon's experience with that law.

These plaintiffs plainly have not carried their burden on standing, however. Resolution of the merits must await another lawsuit (assuming one is filed) brought by plaintiffs who can demonstrate an injury-in-fact sufficient to establish standing.[12] A grant of review in this case would serve no purpose, other than to delay finality in the case unnecessarily. The petition does not present the Court with a legal question of importance. Nor would the outcome of the case change, even if the Court were inclined to grant the petition to review the case for factual error. The Court would simply forestall an evitable outcome. The same is true of delaying action on the petition until after November, as plaintiffs have asked the Court to do.[13]

Plaintiffs' interests, to be sure, are preserved in the interim, for an injunction ensures that terminally ill adults will not have

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[12] While standing may be difficult to show, it is not hard to envision a proper plaintiff, assuming that plaintiffs are correct in their assertions about the inadequacies of Measure 16's procedures. It may be, as plaintiffs hypothesize, that a person who is suicidally depressed and seeking physician assistance in dying due to that depression will not be willing to sue to invalidate Measure 16. Pet. Cert. 11. But family members (*e.g.*, spouse, parent, son or daughter, brother or sister) in such near danger of losing a loved one likely would be able to make the necessary showing of imminent injury. Of course, some individuals may invoke Measure 16 without their family members' knowledge. But not all will, and not all physicians and other health care personnel would fail to alert family members to the terminally ill person's choice. If the number of terminally ill persons likely to act out of severe depression rather than pursuant to a competent and knowing choice is as great as plaintiffs speculate, there should be ample family member plaintiffs to bring that case.

[13] *See* Pet. Motion to Defer Consideration. Delaying a ruling on the petition until after the November 4, 1997, referral may provide plaintiffs and other opponents of Measure 16 with a political advantage in the form of on-going uncertainty about the constitutionality of the law. Plaintiffs properly do not rely on that as a basis to urge the Court to delay a ruling on the petition, however.

the legal ability to make a choice plaintiffs fear they will make for the wrong reasons. Just as surely, however, many Oregonians believe they are significantly prejudiced by delay in resolving this lawsuit. They view Measure 16 not as infringing on their interests, but as securing their personal autonomy and dignity. The injunction and the stay of the Ninth Circuit's judgment denies them the ability lawfully to make a choice that they believe they can make competently, on the basis of sound medical advice, and with the support of family and friends. Those individuals have been deprived of the benefit of the law throughout the course of this case.

For that reason, the Court should not delay a decision on the petition. Because the petition does not present an unsettled legal question of significance and the case is clearly decided correctly on its facts, the Court should deny the petition and bring finality to this case at the earliest opportunity.

CONCLUSION

The petition for writ of certiorari should be denied.

Respectfully submitted,

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August 28, 1997

(6)

Supreme Court, U.S.
FILED
SEP 2 1997
CLERK

No. 96-1824

IN THE SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1996

GARY LEE, M.D., et al.,
Petitioners,

v.

F. DOUGLASS HARCLEROAD, et al.,
Respondents,

On Petition for Writ of Certiorari to the
United States Court of Appeals
for the Ninth Circuit

BRIEF IN OPPOSITION
filed by
RESPONDENTS LEVIN, M.D., AND SHUCK

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ADDITIONAL QUESTIONS PRESENTED

Depending on how the Court resolves the standing issues raised by Petitioners, this case also presents the following questions:

- Does Measure 16 violate the Equal Protection Clause of the Fourteenth Amendment?

- Does Measure 16 violate the Due Process Clause of the Fourteenth Amendment?

- Does Measure 16 violate the Free Exercise Clause or the Establishment Clause of the First Amendment?

Introduction

The Court should deny review, because the standing issues the petition presents are not novel or recurring. If, however, the Court grants review, and if it concludes that Petitioners have standing, it should proceed to decide the case on the merits, rather than remand to the Court of Appeals.

Argument

This Court is a law-developing, not law-applying, forum. Its job is to announce new rules of law for the lower courts to apply to recurring facts. This case, by comparison, involves the straightforward application of settled rules to peculiar facts.

One of these rules is that a person must have "standing" to seek relief in federal court. Another is that standing requires an "injury in fact" -- "an invasion of a legally protected interest which is (a) concrete and particularized . . . and (b) actual or imminent, not conjectural or hypothetical . . . ." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992) (citations and footnote omitted). Applying these rules, the Court of Appeals held that Petitioners lack standing to challenge Oregon's assisted-suicide law, known popularly as Measure 16. *Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997).

Petitioners do not challenge the standing requirement or the requirements for standing, which the Court reaffirmed as recently as three months ago. *See Raines v. Byrd*, 117 S.Ct. 2312, 2317 (1997), and *Bennett v. Spear*, 117 S.Ct. 1154, 1161 and 1163

(1997). Instead, they challenge the lower court's application of those settled rules to their unique, not-likely-to-recur claim.

Their claim is unique, because the law they challenge is. As the Court recently observed, "[i]n almost every State -- indeed, in almost every western democracy -- it is a crime to assist a suicide." *Washington v. Glucksberg*, 117 S.Ct. 2258, 2263 (1997). Oregon is the one American exception. The voters here approved Measure 16 in 1994 after similar initiatives failed in Washington and California. Since that vote

> "many proposals to legalize assisted-suicide have been and continue to be introduced in the States' legislatures, but none has been enacted. And just last year, Iowa and Rhode Island joined the overwhelming majority of States explicitly prohibiting assisted-suicide."

Id. at 2266. Meanwhile, Congress passed -- and the President signed -- the Assisted Suicide Funding Restriction Act of 1997, 42 U.S.C. § 14401 *et seq.*, which prohibits the use of federal funds in support of aid-in-dying, and makes it even less likely that other states will follow Oregon's lead in this area anytime soon.

Because no other state has a law like Measure 16 or seems likely to enact one, a ruling by this Court on what it takes to challenge such legislation would be of little concern to anyone but Oregonians. And even they might soon lose interest, because the law itself may go away or change form in the near future. The Oregon legislature has just put Measure 16 back on the ballot in November 1997. Ore. H. B. 2954 (1997). Voters will be asked then whether to repeal the measure, which, because of the District Court's injunctions in this case, has never been implemented. Even

if Measure 16 survives that vote, it might not emerge intact from the next legislative session. The legislators may -- and probably will, proponents and opponents agree -- amend the law when they next meet. Those amendments may even resolve some of these petitioners' concerns.

This busy court should not spend its valuable time deciding whether Petitioners are entitled, under well-established standing rules, to challenge a law that is not only one-of-a-kind, but has not yet -- and may never -- take effect. The Court should, instead, save review for issues that are unsettled and recurrent. Since the issues here are neither, the Court should deny the petition.

If, instead, the Court grants review, and if, on review, it concludes that Petitioners have standing, it should proceed to decide their claim on the merits, rather than remand to the Court of Appeals. A remand is, of course, the usual practice when the Court overturns a lower court ruling that did not reach the merits. But there have been exceptions to that general rule, *see, e.g., Quinn v. Millsap*, 491 U.S. 95, 106-07 (1989), and this is an exceptional case, because two of the parties might not survive a remand. Petitioner Elsner is terminally ill.[1] So is Respondent Shuck.[2] For them, time is of the essence, and a remand means delay.

These litigants aside, there are, no doubt, many other Oregonians who are terminally-ill and who, like Respondent Shuck,

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[1] The District Court found she is, Pet. App. 59a, and the Court of Appeals assumed she is, *id.* at 10a.

[2] Pet. App. 10a. Two other parties died during the proceedings below -- plaintiff Dutson, while the case was in the trial court, *id.* at 7a, n. 1, and intervenor Vernon, while it was in the Court of Appeals.

want the comfort and protection of Measure 16. They, like he, might not have time for a decision on remand (and another, inevitable cert petition). For their sake and his, the Court should take all of this case -- standing and merits -- if it takes any of it, and thus resolve, sooner, not later, whether Measure 16 is constitutional.

For the same reason, the Court should rule promptly on the cert petition, instead of waiting until after the November plebiscite, as Petitioners propose in their "Motion to Defer Consideration of Petition For A Writ of Certiorari."

Conclusion

The Court should deny review. But if it grants review, it should direct briefing on the merits, as well as on the standing issues raised in the Petition.

Respectfully submitted,

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September 2, 1997

Supreme Court, U.S.
FILED
SEP 2 1997
CLERK

(6)

No. 96-1824

IN THE
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On Petition for Writ of Certiorari to the
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for the Ninth Circuit

RESPONDENTS' BRIEF IN OPPOSITION
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QUESTION PRESENTED

Whether the facts in this record establish that plaintiffs personally will suffer an imminent, concrete, and non-speculative injury sufficient to give them standing to challenge Oregon's Death With Dignity law.

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INTRODUCTION

Respondents are the three chief petitioners who sponsored the Oregon Death With Dignity Act in 1994.[1] Respondents have reviewed the State of Oregon's brief in opposition to the petition for writ of certiorari and join in all aspects contained therein, including the question presented. Respondents make the following additional points.

STATEMENT OF JURISDICTION

While plaintiffs may be properly before this court on procedural grounds, the "case" or "controversy" requirements of Article III are not met.

STATEMENT OF THE CASE

The Oregon Death With Dignity Act (Act), codified at Or. Rev. Stat. 127.800 *et seq.*, was passed into law by Oregon voters on November 8, 1994.[2] It establishes the statutory framework

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[1] *See* Or. Rev. Stat. 250.045 (chief petitioners required to initiate a measure).

[2] Article IV, section 1, of the Oregon Constitution provides, in part:

> The legislative power of the state, *except for the initiative and referendum powers reserved to the people*, is vested in a Legislative Assembly, consisting of a Senate and a House of Representatives [emp. supp.].

For purposes of constitutional review, it is irrelevant that the voters rather than the state legislature enacted the statute. *Citizens Against Rent Control v. City of Berkeley*, 454 U.S. 290, 295, 102 S.Ct. 434, 70 L.Ed.2d 492 (1981).

within which a competent dying adult patient may legally request a prescription for medication "for the purpose of ending his or her life in a humane and dignified manner." §2.01, Pet. Cert., 22a. Under Oregon's Constitution, the Act would have taken effect on December 8, 1994, thirty days after the November 8 election in which it was adopted by a majority of voters. Or. Const., Art. IV, § 1(4)(d).

However, on November 23, 1994, fifteen days after the election and fifteen days before the Act would have taken effect, plaintiffs filed a complaint seeking declaratory and injunctive relief. Plaintiffs alleged that the Act violates the Equal Protection and Due Process Clauses of the Fourteenth Amendment of the Constitution (Counts One, Two and Four), statutory and First Amendment rights of freedom to exercise religion and to associate (Count Five), and the Americans with Disabilities Act (Count Three). *See* Third Amended Complaint.

The district court prevented the Act from taking effect, first by issuance of a temporary restraining order on December 7, 1994, then by issuance of a preliminary injunction on December 27, 1994, and then by issuance of a declaratory judgment and permanent injunction entered August 3, 1995. Although the district court was reversed by the court of appeals, the court of appeals nonetheless stayed its mandate pending further review by this Court. Almost three years later, the voter-approved Act has never been implemented.[3]

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[3]More Oregon voters voted on the Act than voted for anything else on the ballot that year, including the gubernatorial races combined. *Source*: 1995-96 Oregon Blue Book, pp. 327, 354 (complied and published by Phil Keisling, Secretary of State, State of Oregon).

REASONS TO DENY THE WRIT

A. Introduction

On this appeal, issues of jurisdiction, including standing and ripeness, are not only threshold, they are dispositive. Because the Act was never implemented, the pre-litigation facts are not extensive. To the extent that such facts exist, they cut against plaintiffs' claim of standing. *See* State of Oregon's Brief in Opposition, 1-7.

B. Plaintiff Janice Elsner

In their first question presented, plaintiffs mislead the Court, arguing that:

> Janice Elsner is dying. Recurring clinical depression makes her vacillate between wanting suicide and life.

See Pet. Cert., i.

Ms Elsner is not terminally ill now, and she may not be for another ten years. *See* State's Brief, 4. Nor is there any evidence in the record that Ms Elsner "vacillate[s] between wanting suicide and life." *See* State's Brief, 1-7. Plaintiffs' first question is an incredible distortion of the record on this appeal.

1. No Future Injury

In its opposition brief, the State fully details the complete lack of any future injury to plaintiffs. That effort will not be

repeated here. It may be instructive to note, however, that although standing has repeatedly been raised as a defense throughout this litigation,[4] plaintiffs treat standing in a secondary fashion. For example, in the court of appeals, it was not until page 49 of their brief that plaintiffs first addressed the issue of standing, and that response was superficial, arguing that "the matter is really quite simple" because the "*empirical* facts" reveal that:

> (1) persons with a terminal disease are at a greatly increased risk for depression; (2) depression carries with it a serious risk of becoming suicidal; and (3) primary care physicians regularly miss suicidal depression in their own patients.

Appellees' Brief, at 49 (emp. supp.).

For this Court to find standing on these *empirical non-individualized* "facts" would result in an unprecedented expansion of the standing doctrine; a dream come true for federal court plaintiffs. Although plaintiffs continue to advance their multi-link speculative arguments (*see e.g.*, Pet. Cert., 21), they have also attempted to recast their case as one having *individualized* facts. It is due to the complete paucity of any individualized facts, however, that the State so readily dismantles plaintiffs' claim of standing. In sum, plaintiffs argument in support of an individualized, imminent, concrete, and non-speculative injury is

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[4]In the trial court, *see* defendants' motions to dismiss (CR 58), motions to stay and/or modify (CR 92, 95), and motions for summary judgment (CR 150), all of which asserted plaintiffs' lack of Article III "case or controversy," standing, and ripeness. In the court of appeals, *compare* Appellants' Brief (filed by Goodwin, Coombs Lee and Sinnard), pp. 11-24 *with* Appellees' Brief, pp. 49-50.

either speculative (as it was in the court of appeals), or misleading (as it is before this Court).[5]

2. No Present Injury

It is perhaps because plaintiffs lack an imminent, concrete, and non-speculative *imminent* injury that plaintiffs attempt, now more than ever, to establish an individualized *present* ("stigmatic") injury. The State fully rebuts plaintiffs' claim of a present injury (*see* State's Brief, 18-21) and, once again, that effort will not be repeated here. Plaintiffs have, however, committed an error of fact and law that must be corrected.

a. The Standard of Care

In an attempt to claim a present "stigmatic" injury, plaintiffs argue that under section 4.01 of the Act, the standard of care for terminally ill patients is lowered from the objective reasonable standard of care to the subjective good faith standard of care.[6] Pet. Cert., 4. This theme runs throughout plaintiffs'

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[5]Why then, one might ask, is Ms Elsner involved in this litigation? The record reveals that Ms Elsner is politically opposed to the Act, that she worked to defeat it during the 1994 campaign, and that her participation in this litigation was a continuation of that effort. *See* State's Brief, 6. While such an admission is not dispositive on the issue of standing, it does explain how Ms Elsner came to be a plaintiff without an injury.

[6]Section 4.01 of the Act (immunities) provides:

> (1) No *person* shall be subject to civil or criminal liability or professional disciplinary action for participating in *good faith* compliance with this Act. This includes being present when a qualified patient takes the prescribed medication * * * .

Pet. Cert., 30a (emp. supp.).

petition. *See* Pet. Cert., 2, 4, 8-9, 10-12, 15-16, 19, 22, 25, 29-30. At one point, plaintiffs even argue that:

> This reduced standard of care [good faith] applies to the *diagnoses of whether a person is terminally ill* (having less than six months to live).

See Pet. Cert., 4 (fn omitted, emp. supp.).

Plaintiffs are wrong and this is a careless assertion, for the Act expressly provides that reasonable medical judgment is required when making a diagnosis that a patient is terminally ill:

> "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within *reasonable medical judgment*, produce death within six (6) months.

See §1.01(12), Pet. Cert., 22a (emp. supp.).

Consequently, the subjective good faith standard of care does not apply to the diagnosis of terminal illness. Moreover, the standard of care is not lowered in any instance under the Act.

b. Statutory Interpretation

Oregon has a well established body of law that governs statutory interpretation. When interpreting a statute, the court's task is to discern the intent of the legislature. Or. Rev. Stat. 174.020. To determine legislative intent, the court first examines the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or. 606, 610-612, 859 P.2d 1143 (1993) (explaining

methodology). If, after doing so, using aids to statutory construction that bear directly on the interpretation of the text of the statute within its context, the legislative intent is unclear, the court considers legislative history. *Id.*, at 611-12. If after consideration of text, context, and legislative history, the intent of the legislature remains unclear, the court may then resort to general maxims of statutory construction to aid in resolving the remaining uncertainty. *Id.*, at 612; *see also*, *Huff v. Great Western Seed Co.*, 322 Or. 457, 909 P.2d 558 (1995) (reversing three prior decisions that failed to abide by this methodology). This approach to statutory interpretation applies equally to laws enacted by the legislature and the people. *See e.g., Roseburg School Dist. v. City of Roseburg*, 316 Or. 374, 378-379 & n 5, 851 P.2d 595 (1993).

The first level of analysis, the text of the statute itself, is the starting point; it provides the best evidence of the legislature's intent. *PGE v. Bureau of Labor and Industries*, 317 Or. at 610. In the instant case, the text of the Act expressly provides that "reasonable medical judgment" must be exercised when diagnosing a terminal disease. §1.01(12), Pet. Cert., 22a. Elsewhere the Act also provides that "[n]o *person* shall be subject to civil or criminal liability or professional disciplinary action for participating in *good faith* compliance with this Act." *See* §4.01 (quoted fully in fn 6 *supra*), Pet. Cert., 30a (emp. supp.).

The issue then is how to interpret section 1.01(12) (reasonable medical judgment) and section 4.01(1) (good faith compliance). One solution is to adopt the approach assumed here by plaintiffs, *i.e.*, allow the words "good faith compliance" to negate the words "reasonable medical judgment." This interpretation, however, is inappropriate, for a court may not insert what

has been omitted or omit what has been inserted. Rather, the court must give effect to all words. *See* Or. Rev. Stat. 174.010.[7]

Another aid to statutory interpretation compels the same result. Or. Rev. Stat. 174.020 provides that a specific intent shall control a general one.[8] Here the specific intent is that a physician shall exercise "reasonable medical judgment." §1.01(12), Pet. Cert., 22a. The general intent is that persons who act in "good faith compliance" are immune from liability. §4.01, Pet. Cert., 30a. Because the specific intent controls the general intent, the specific requirement of reasonable medical judgment must be given effect. For this additional reason, plaintiffs' interpretation is wrong.

It is instructive to note that where the Act refers to "good faith compliance," it is referring to *persons* generally. This makes sense because the Act, construed as a whole, contemplates all persons who might participate, professionals and nonprofessionals alike. However, where the Act refers to what is obviously one of

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[7]Or. Rev. Stat. 174.010 provides:

> **General rule for construction of statutes.** In the construction of a statute, the office of the judge is simply to ascertain and declare what is, in terms or in substance, contained therein, not to insert what has been omitted, *or to omit what has been inserted*; and where there are several provisions or particulars such construction is, if possible, to be adopted as will *give effect to all* [emp. supp.].

[8]Or. Rev. Stat. 174.020 provides:

> **Legislative intent; general and particular provisions and intents.** In the construction of a statute the intention of the legislature is to be pursued if possible; and when a general and particular provision are inconsistent, the latter is paramount to the former. So a particular intent shall control a general one that is inconsistent with it.

the many roles fulfilled by a physician, then the act requires "reasonable medical judgment." Contrary to plaintiffs' argument, nowhere does the Act suggest that the "good faith" requirement of §4.01 is a substitute for the applicable standard of care for physicians, pharmacists, nurses, or any other health care provider who might choose to participate under the Act.[9]

Assuming *arguendo* that a lower standard of care does apply to physicians, and further assuming that the lower standard or care creates a constitutional problem ("stigmatic" injury) (and the State has fully rebutted this point), the appropriate solution is to sever the offending provision (*i.e.,* sever the words "good faith"). The Act contains a severability clause:

> Any section of this Act being held invalid as to any *person or circumstance* shall not affect the application of any other section of this Act which can be given full effect without the invalid section or application.

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[9]Medical malpractice cases are simply negligence actions against medical professionals. *Rogers v. Meridian Park Hospital*, 307 Or. 612, 619, 772 P.2d 929 (1989). The fundamental issue, as in all negligence cases, is whether the defendant breached the standard of care. *Id.* Plaintiffs correctly point to Or. Rev. Stat. 677.095 as the standard of care in Oregon. Pet. Cert., 12. That statute merely codifies the common law of negligence, *id.*, which requires that a physician exercise the applicable standard of "reasonable care." *Whinston v. Kaiser Foundation Hospital*, 93 Or. App. 528, 531-532, 763 P.2d 177 (1988).

To prevail in a medical malpractice case, the plaintiff must establish (1) the degree of care, skill and diligence used by ordinarily careful physicians in the same or similar circumstances; (2) that the defendant failed to use "*reasonable*" care; and (3) that as a result of the defendant's failure to exercise "*reasonable*" care the plaintiff suffered injuries. *Zacher v. Petty*, 103 Or. App. 8, 14, 797 P.2d 1042 (1990) (applying Or. Rev. Stat. 677.095); *rev on othr grnds*, 312 Or 590 (1992).

See §5.01, Pet. Cert., 31a (emp. supp.).

Consequently, if the words "good faith" offend the Constitution, the appropriate solution is to sever them from the Act. Indeed, this is required by Oregon law. *See* Or. Rev. Stat. 174.040 (severability).[10]

In sum, while applying any one (or all three) of the above statutory aids to interpretation to the text and context of the Act, one thing is obvious: the interpretation urged here by plaintiffs (lowered standard of care) is impermissible.

Plaintiffs must lose this argument for yet another reason. Oregon courts are "committed to the proposition that statutes are to be construed so as to satisfy the constitution unless no other construction is possible." *See State v. Lajoie*, 316 Or. 63, 95, 849 P.2d 479 (1993); *see also, State v. Buttrey*, 293 Or. 575, 596, 651 P.2d 1075 (1982) ("it is our obligation to avoid interpreting statutes in a way that creates serious doubts of their constitutionality"); *Bernstein Bros. v. Dept. of Rev.*, 294 Or. 614, 621, 661 P.2d 537 (1983) ("we should construe and interpret statutes in such a manner as to avoid any serious constitutional problems"). Federal courts

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[10]Or. Rev. Stat. 174.040 provides:

> **Severability.** It shall be considered that it is the legislative intent, in the enactment of any statute, that if any part of the statute is held unconstitutional, the remaining part shall remain in force unless:
>
> (1) The statute provides otherwise;
>
> (2) The remaining parts are so essentially and inseparably connected with and dependent upon the unconstitutional part that it is apparent that the remaining parts would not have been enacted without the unconstitutional part; or
>
> (3) The remaining parts, standing alone, are incomplee and incapable of being executed in accordance with the legislative ntent.

do the same. *Communications Workers v. Beck*, 487 U.S. 735, 762, 108 S.Ct. 2641, 101 L.Ed.2d 634 (1988) ("federal statutes are to be construed so as to avoid serious doubts as to their constitutionality").

The requirement that courts should implement and preserve a statute, as opposed to imagining reasons to defeat it, is so compelling that Oregon courts will reverse their own precedent to avoid a newly recognized constitutional violation. *Hunter v. State of Oregon*, 84 Or. App. 698, 703, 735 P.2d 1225 (1987) *rev on othr grnds*, 306 Or. 529 (1988) (overturning three prior decisions that interpreted a statute giving rise to a constitutional problem). Admittedly, this approach does not suit plaintiffs' needs, because they seek only to defeat the statute.[11]

C. Plaintiffs/Drs. Gary Lee and William Petty

1. No Patients

In their second question presented, plaintiffs again mischaracterize the record when they state that "Drs. Gary Lee and William Petty assert their terminally ill patients' interests * * * ." *See* Pet. Cert., i. No such patient has ever been identified by name or profile, in the district court, in the court of appeals, or in this

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[11]Ironically, history demonstrates that once this Act is implemented, opponents will work to interpret it narrowly, restricting its scope and placing as many hurdles between patients and physicians as possible. At the same time, opponents will also seek to interpret the Act so as to create the greatest protections for patients and the greatest liabilities for professionals. Such is the political reality of social issues litigated in the courts. For the time being, however, in order to defeat the statute, plaintiffs work in the opposite direction, seeking to interpret the Act so as to harm themselves, in a misguided effort to claim an Article III injury.

proceeding. Indeed, no patient has ever requested that either doctor represent their interests. (CR 139-147; CR 149; CR 150).

As pointed out by the State, Drs. Lee and Petty are themselves personally opposed to the Act (*see* State's Brief, 6) and that is why they are plaintiffs in this litigation. This Court has, however, made clear that standing "is not to be placed in the hands of concerned bystanders who will use it simply as a vehicle for the vindication of value interests." *Diamond v. Charles*, 476 U.S. 54, 62, 106 S.Ct. 1697, 90 L.Ed.2d 48 (1986) (internal quotation marks omitted). Attempts by doctors Lee and Petty to recast their involvement on appeal to suggest that they are representing certain patients is pre-textual and "trivializes our concern with confining standing to effective proponents of third-party rights." *Hong Kong Supermarket v. Kizer*, 830 F.2d 1078, 1082 (9th Cir. 1987).

D. This Matter Was Correctly Decided

In an effort to revive their district court victory, plaintiffs naturally defend the district court's analysis, which upon close examination, is not defensible.

1. The District Court's Error

The district court found that "the risk of death is a sufficient injury for * * * [Ms] Elsner and properly a basis of standing if sufficiently connected to [the Act]." Pet. Cert., 59a. The district court reasoned that because Ms Elsner was dying, and because she had experienced depression in the past, she was:

> likely to become depressed and unable to control the timing or severity of that depression. There is

> significant evidence that * * * [Ms Elsner is] at a significant risk of harm due to circumstances beyond her control with the [Act] in effect.

Pet. Cert., 60a (footnote omitted).

Accordingly, the district court found that Ms Elsner had "standing to assert a *facial* challenge." *Id.* (emp. supp.). However, the primary authorities relied upon by the district court to confer standing upon Ms Elsner simply do not support the propositions claimed by the district court.

2. The District Court Was Properly Reversed

a. *Kines v. Day & Dombrowski v. Pfister*

First, the district court has accomplished in one published opinion what federal court plaintiffs have, until today, only dreamed about. For, in the words of the district court--

> it is not necessary to demonstrate a specific or immediate harm when challenging the constitutionality of a statute *on its face*. *Kines v. Day*, 754 F.2d 28, 30 (1st Cir. 1985) (citing *Dombrowski v. Pfister*, 380 U.S. 479, 486 (1965)) [emp. supp.].

Pet. Cert., 57a.

If this is true, then Article III no longer applies to facial challenges. The district court, however, was wrong, and its reliance on *Kines v. Day*, misplaced. Both *Kines v. Day* and *Dombrowski v. Pfister* are free speech cases and the district court

misconstrued an exception that applies only to claims involving free speech. *Dombrowski v. Pfister*, 380 U.S. 479, 486, 85 S.Ct. 1116, 14 L.Ed.2d 22 (1965) ("[b]ecause of the sensitive nature of constitutionally protected expression * * * [w]e have fashioned this exception to the usual rules governing standing * * * ").

b. *Dimarzo v. Cahill*

Second, the district court writes that--

> One need not wait for the life-threatening event to occur before concluding that a real and present threat exists. *Id.* This rule applies when a plaintiff has little control over whether the life-threatening event will occur. *Id.*

Pet. Cert., 57a-58a, *citing Dimarzo v. Cahill*, 575 F.2d 15, 18 (1st Cir. 1978) *cert den* 439 U.S. 927 (1978).

The district court once again misstates the law. In *Dimarzo v. Cahill*, the plaintiffs were inmates incarcerated in a structure not safe from fire. Moreover, the inmates introduced evidence of past fires, including one incident where an inmate was trapped by fire. It was due to this *very real, specific, and historically proven threat of fire to jailed inmates* that the First Circuit concluded that "[o]ne need not wait for the *conflagration* before concluding that a real and present threat exists [emp. supp.]." *Dimarzo v. Cahill*, 575 F.2d at 18.

Dimarzo v. Cahill has no application here. First, Ms Elsner is not trapped anywhere by anyone. She has made her wishes known and can identify no one who will harm her. *See* State's

Brief, 5. Secondly, in order for Ms Elsner to bring herself within the reach of *Dimarzo v. Cahill*, she would, at a minimum, need to (i) identify a real and present threat of injury, (ii) establish that it has occurred *to her* in the past, and (iii) further establish that it will occur *to her* again in the future. Ms Elsner has made no such showing, nor can she. Her lack of standing becomes crystal clear once it is realized that her so-called "facts" are in no way related to her personal situation. *See* State's Brief, 5-6.

c. *Allen v. Wright*

Third, and in reliance upon *Allen v. Wright*, 468 U.S. 737, 757-758, 104 S.Ct. 3315, 82 L.Ed.2d 556 (1984), the district court wrote that plaintiffs do "not lack standing merely because an injury may be an indirect product of a defendant's conduct." (Pet. Cert., 58a). The district court again misstated the law. In *Allen v. Wright*, this Court actually said that:

> the indirectness of the injury may * * * make it *substantially more difficult to meet the minimum requirement of Art. III* * * * .

Id., at 757-58.

Moreover, in *Allen v. Wright*, this Court found against standing, describing plaintiffs' injury as "entirely speculative," "just as speculative," and as "pure speculation" because the alleged injury was *highly indirect*, "result[ing] from some third party not before the court." *Allen v. Wright*, 468 U.S. at 758. The same is true in the instant case, which is why the district court was properly reversed by the court of appeals.

d. *Golden v. Zwickler*

Fourth, the district court wrote that:

> There is no precise test for determining the difference between an abstract question and an Article III controversy, rather it is necessarily a question of degree. *Golden v. Zwickler*, 394 U.S. 103, 108, 89 S.Ct. 956, 22 L.Ed.2d 113 (1969).

Pet. Cert., 58a.

The plaintiffs in *Golden v. Zwickler* sought a declaratory judgment and injunctive relief from operation of a state statute. This Court found that the circumstances did not present a case or controversy of sufficient "immediacy and reality" and denied relief. Moreover, viewed in its full context, the *Golden v. Zwickler* opinion does not support the district court's analysis:

> The federal courts established pursuant to Article III of the Constitution *do not render advisory opinions*. * * * [Rather,] "*concrete legal issues, presented in actual cases, no abstractions*" *are requisite*. This is as true of declaratory judgments as any other field. The difference between an abstract question and a "controversy" * * * is necessarily one of degree * * * *the question in each case is whether the facts alleged, under all the circumstances, show that there is a substantial controversy, between parties having adverse legal interests of sufficient immediacy and reality to warrant the issuance of a declaratory judgment.*

Golden v. Zwickler, 394 U.S. at 108 (emp. supp., citations and some quotation marks omitted).

Like the plaintiffs in *Golden v. Zwickler*, the plaintiffs here have not alleged, much less established facts that under *all the circumstances* show that there is a *substantial controversy*, between parties having adverse legal interests of sufficient *immediacy and reality*. In the present case, there is no controversy, much less a "substantial controversy *between [the] parties*." Nor is there any immediacy.

In sum, the district court linked together a series of propositions severely removed from their proper context. Under these circumstances, the district court was properly reversed by the court of appeals. With respect to Ms Elsner, the Ninth Circuit specifically found that her claim was based on a "chain of speculative contingencies." Pet. Cert., 11a. With respect to the other plaintiffs, the Ninth Circuit found that they had "failed to allege a 'concrete and particularized' injury." Pet. Cert., 18a. A few months ago, this Court reaffirmed those principles:

> To meet the standing requirements of Article III, a plaintiff must allege *personal injury* fairly traceable to the defendant's allegedly unlawful conduct and likely to be redressed by the requested relief. *Allen v. Wright,* 468 U.S. 737, 751, 104 S.Ct. 3315, 3324, 82 L.Ed.2d 556 (1984) [emp. orig.]. For our purposes, the italicized words in this quotation from *Allen* are the key ones. We have consistently stressed that a plaintiff's complaint must establish that he has a "personal stake" in the alleged dispute, and that the alleged

> injury suffered is particularized as to him. *See, e.g., Lujan*, 504 U.S., at 560-561 and n. 1, 112 S.Ct., at 2163 and n. 1 * * * .

Raines v. Byrd, ___ U.S. ___, 117 S.Ct. 2312, 2317 (1997).

Plaintiffs' theory of standing misses this mark by a wide margin. With respect to Ms Elsner, her allegations amount to nothing more than a claim that some*where*, some*time*, some*one* other than the defendants, is going to harm some*one* other than the plaintiffs. With respect to the patients' interests allegedly represented by Drs. Lee and Petty, on this record, we do not know who those patients are, the nature or their circumstances, why they cannot represent their own interests, or if they even exist.

CONCLUSION

This litigation presents interesting policy questions, but simple legal questions. The petition for writ of certiorari should be denied.

Respectfully submitted,

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September 2, 1997

Supreme Court, U.S.
FILED
SEP 10 1997
CLERK

(7)

No. 96-1824

In the
Supreme Court of the United States
October Term, 1996

GARY LEE, M.D., individually and on behalf of his terminally ill patients; WILLIAM PETTY, M.D., individually and on behalf of his terminally ill patients; JANICE ELSNER, individually and as representative of a class of terminally ill patients; et al.,

Petitioners,

v.

F. DOUGLASS HARCLEROAD, et al.,

Respondents.

On Petition for a Writ of Certiorari to the
United States Court of Appeals for the Ninth Circuit

REPLY TO BRIEFS IN OPPOSITION

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I. This is no 'mere' standing case; it poses undecided, profound, and nationally important standing issues.

This case poses standing issues, but not 'mere' standing issues. They are extraordinary, undecided, profound, nationally important. 1) Who may challenge a regime of assisted suicide that imposes disparate treatment on terminally ill persons? 2) Who may challenge an assisted suicide scheme that requires persons morally opposed to assisting suicide to participate in it? 3) Is stigmatic injury, recognized by this Court and the Sixth Circuit but now rejected by the Ninth Circuit, a proper ground for standing?[1] 4) If physicians may represent their terminally ill patients who want assisted suicide, may not physicians also represent their terminally-patients who want the protections of Oregon's presumptions and laws against assisted suicide?

This Court said that a "State's prohibition on assisted suicide ... both reflects and advances its commitment to" "an unqualified interest in the preservation of human life." *Washington v. Glucksberg*, 117 S. Ct. 2258, 2272 (1997) (quotation marks and citation omitted). If Oregon advances its commitment to protecting the lives of its citizens by a ban on assisted suicide, but refuses to do so for terminally ill persons, then should not terminally ill citizens have standing to challenge such a stigmatic injury?

This Court said that a ban on assisted suicide for all persons "goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and societal indifference." *Id.* at 2273 (internal quotation marks and citation omitted). A "State's assisted-suicide ban reflects and reinforces its policy that the lives of terminally ill ... people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same way as anyone else's." *Id.* If Oregon refuses to protect terminally ill

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[1]The Sixth Circuit clearly recognized stigmatic injury for standing in circumstances closely analogous to those of this case. *See infra* at 4 n.2. The Ninth Circuit's refusal to do so in the present case creates a conflict between the circuits, a reason for granting certiorari.

persons from coercion and prejudicial stereotypes, refuses to equally value their lives, and declines to interpret and treat their suicidal impulses in the same way that it protects others, then may not terminally ill persons challenge this equal protection violation?

This Court said that "legal physician-assisted suicide could make it more difficult for the State to protect depressed or mentally ill persons ... from suicidal impulses." *Id.* May not terminally ill persons subject to this risk challenge the law which strips them of the same presumptions and protections afforded other Oregonians without having to be in the throes of a suicidal depression that makes them unwilling and unable to sue to protect their rights?

Remarkably, Oregon says "no." The State concedes that "[i]t may be ... that a person who is suicidally depressed and seeking physician-assistance in dying due to that depression will not be willing to sue to invalidate Measure 16." *Or. Br.* at 23 n.12.

The State's solution? Maybe family members would have standing and bring a case. *Id.* Of course, as the State admits, family notification is not required, but, Oregon argues, "[i]f the number of terminally ill persons likely to act out of severe depression ... is as great as plaintiffs speculate, there should be ample family member plaintiffs to bring that case." *Id.*

Never before has the vindication of one's rights required reliance on the vicissitudes of family awareness and willingness. Yet, with life at stake, this is the State's only solution. And while we wait for such a possible case, vulnerable people will be dying against their true wishes because "[t]hose who attempt suicide—terminally ill or not—often suffer from depression or other mental disorders." *Glucksberg*, 117 S. Ct. at 2272. And "[t]he New York Task Force ... expressed its concern that, because depression is difficult to diagnose, physicians ... often fail to respond adequately to seriously ill patients' needs." *Id.* at 2273.

Finally, if Oregon were correct in its disputed assertion that no Petitioner has standing under ordinary rules, then this case presents the *undecided* question of whether the rules of standing should be extended to accommodate review of laws such as Measure 16. Plaintiff Eric Dutson's death of AIDS before the trial court

decision indicates that this is a case that is capable of repetition yet evading review. If only people who actually die within six months can prosecute such a case, then Measure 16 can never be tested for constitutionality.

The States and the courts need the guidance of this Court. As states experiment with assisted suicide issues, their experiments must be open to constitutional scrutiny. How and by whom these experiments may be tested is clearly a 'certworthy' question.

II. Terminally ill Petitioners have present, stigmatic injury and have claimed so from the beginning.

The discrimination created by Measure 16 causes an immediate, stigmatic injury to the terminally ill Petitioners, *Pet.* at 23-26, an injury not contingent on future harm resulting from Measure 16's inadequate "safeguards." It exists because Measure 16 renders them innately inferior to other Oregonians, and therefore unworthy of the full and unqualified protection of criminal and civil law against assisted suicide provided to other Oregonians. *See Heckler v. Mathews*, 465 U.S. 728, 739 (1984); *see also Br. Amici Curiae in Support of Pet. For Writ of Cert. on Behalf of American Disabled for Attendant Programs Today et al.* at 8-18.

In response, Oregon claims that the terminally ill can suffer no cognizable harm "unless and until they obtain a lethal prescription by following all of the special procedures the Measure 16 requires." *Or. Br.* at 18. They must first obtain the lethal prescription, then compete for the presumptions and protections of law sheltering other Oregonians from assisted suicide.

But any "allegation that some discriminatory classification prevented the plaintiff from competing on an equal footing in its quest for a benefit" states an injury sufficient to establish standing. *Northeastern Florida Contractors v. Jacksonville*, 113 S. Ct. 2297, 2304 (1993). The plaintiff need not allege the competition had been entered. *Id.* Here, terminally ill persons cannot equally compete for the benefit of Oregon's protective assisted suicide laws. They need not allege they have successfully excluded themselves from the protection of these laws before they can complain that such a

discriminatory exclusion exists.[2]

The State claims an immediate, stigmatic injury "is not alleged in the complaint or established in the record." *Or. Br.* at 19. But all the Petitioners specifically claimed such a harm:

> Oregon has by Ballot Measure 16 determined that the lives of persons who have the disability of a terminal disease, who are suffering from depression, mental and/or emotional disability, or undue influence, are not entitled to being protected from self-harm and assisted suicide by Oregon law. [*Third Amended Complaint* at ¶ 31.]

The Petitioners claimed "imminent" harm (*id.* at ¶ 21); they alleged that "Ballot Measure 16 creates a class of terminally ill persons whom it strips of these [protective legal] benefits afforded others." *Id.* at ¶ 51.[3]

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[2]In *Neighborhood Action Coalition v. Canton*, 882 F.2d 1202 (6th Cir. 1989), the court found standing based on an allegation that, as a result of a racially discriminatory city policy, there was "little or no police response" to neighborhood calls. *Id.* at 1017. The plaintiff in *Canton* was not required to allege that criminals were in fact poised outside neighborhood doors prepared to deprive residents of life or property in the absence of adequate police protection. Likewise, the terminally ill in this case need not stand poised at the brink of state-sanctioned suicide before they may complain that the State has opened such a chasm in its law before them.

In *Smith v. City of Cleveland Heights*, 760 F.2d 720 (6th Cir. 1985), *cert. denied*, 474 U.S. 1056 (1986), the court found that an African-American resident of the City had standing because the City's housing policy at issue created a stigmatic injury by "directly affect[ing] [the plaintiff's] interest in his own self-respect, dignity and individuality in his own town" through "imposing a badge or label of inferiority on him based purely on race." *Id.* at 722. He was compelled to live out "daily routines and neighborhood interactions as a member of a race which his own City labels as undesirable." *Id.* Although the City's motive for unequal treatment may have been "benign," that the plaintiff had to "live on a daily basis with the sense of disrespect officially established by law" was sufficient injury to warrant standing. *Id.* at 723. The terminally ill in this case suffer an even greater immediate stigmatic injury as the result of Measure 16—they must wear a label of inferiority announcing that their very lives are less worthy of protection than the lives of all other Oregonians.

[3]Janice Elsner also alleged that Measure 16 "increas[ed] the vulnerability of

The record was reviewed by the trial court before it found there was sufficient evidence to support allegations of injury. *App.* at 59a-60a.[4] The court also found that the lower standard of care for the terminally ill imposed by Measure 16 in itself "would confer standing on the plaintiffs" for the purpose of an equal protection challenge, *id.* at 1427, i.e., the record supported an allegation of immediate and stigmatic harm if Measure 16 took effect.[5]

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persons like herself to request assisted suicide despite their true intent." *Id.* at ¶ 8. Plaintiff Eric Dutson asserted that "Ballot Measure 16 rests on the judgment that the lives of patients who have the disability of a terminal disease are less deserving of protection than others." *Id.* at ¶ 6.

[4]For example, Janice Elsner testified that "Measure 16 creates a financial incentive to subject me to undue influence to end my life prematurely, and terminal illness could render me susceptible to such influence" and "[w]ith assisted suicide the law, the possibility of suicide will crowd in upon one." *Answers to First Set of Interrogatories*, No. 3. She testified that she believed that"[e]nding one's life prematurely forfeits [opportunities for courage, fortitude, and increased intimacy], and Ballot Measure 16 creates inducements for the terminally ill to forfeit them, and incentives for others to encourage them to do so." *Elsner Aff.* at ¶ 4.

[5]In an effort to avoid a present, stigmatic injury, Respondents Goodwin, Lee & Sinnard assert that the lowered "good faith" standard applies neither to the diagnosis of terminal disease nor "in *any instance* under the Act." *Goodwin Br.* at 5-6 (emphasis added). This would make the "good faith" clause superfluous and is contrary to the holding of the district court, the only court to reach the merits of this case:

> The court finds that there is no set of facts under which it would be rational for terminally ill patients under Measure 16 to receive a standard of care from their physicians under which it did not matter whether they acted with objective reasonableness, according to professional standards. This defect goes to the very heart of the State's reliance on person's consent to die. *The physician is allowed to negligently misdiagnose a person's condition and competency and negligently prescribe a drug overdose, so long as those actions are in "good faith."* [*App.* at 51a (emphasis added).]

III. This Court is not required to decide facts to recognize Janice Elsner's standing; the district court has already decided the facts and was not reversed.

Because this Court does "not [ordinarily] grant a certiorari to review evidence and discuss specific facts," *United States v. Johnston*, 268 U.S. 220, 227 (1925), Oregon tries to create a factual issue by alleging that Janice Elsner is not really terminally ill. *Or. Br.* at 12. Respondents Levin and Shuck correctly concede that "Petitioner Elsner is terminally ill," noting that "[t]he District Court found she is, Pet. App. 59a, and the Court of Appeals assumed she is, *id.* at 10a." *Levin Br.* at 3 & n.1. There is no need for this Court to reopen the matter here. The lower courts are fully supported by the record.

As the district court noted, Measure 16 affects any adult with an "incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months." *App.* 59a. Applying this standard, the court held that Janice Elsner was "qualified" under Measure 16 and denied standing to other patients who were not. *Id.* at 59a-60a & n.1.

The court noted that Janice had been diagnosed with "a progressive form of muscular dystrophy," a terminal disease, and that "she has already lived longer than doctors expected," i.e., she had been given a prognosis of death in less than six months. *Id.* at 59a. In contrast, the court denied standing to Claudine Stotler, who "was told in 1992 that she had six months to live," due to metastasized cancer for which she had multiple surgeries from 1992-1994, but who "ha[d] not received an update on her prognosis." *Id.* at 60a n.1.

The district court based its findings on the record. *App.* at 60a. And the record shows that Janice stated that she "had dermatomyositis, a progressive form of muscular dystrophy," that she had "already lived longer than expected," that sometimes "during the last three years [she] had been so weak that [she] could not turn over in bed," that at such times she "was limited to a liquid diet because [she] was too tired to eat," that she "spen[t] much of [her]

time in bed," and when not in bed she was "confined to a wheelchair." *Elsner Aff.* at 2. When asked what prognosis she had been given, she said "[a]t the moment we're on a day-to-day basis." *Elsner Dep.* at 13. It is true, as Oregon notes (*Or. Br.* at 4), that in response to the specific question of whether "anybody had suggested or told you that you ought to put your things in order, that you might not be around in the next five months or six months," she answered "[n]o." *Id.* at 13-14. However, this response was plainly provoked by the manner in which the question was framed: She simply meant that no one had told her to put her affairs in order, not that she had been told that she would not imminently die. With her "day-to-day" response, she had already indicated she had been told she could die any day.

The Ninth Circuit, ignoring this evidence in its own overly-literal approach to Elsner's testimony, stated that Janice "ha[d] not been given a prognosis of less than six months to live." *App.* at 10a, 15a n.2. However, the court proceeded to assume she was terminally ill for its analysis. *Id.* It noted, in any event, "that the named doctors and residential care facilities could assert the interests of their terminally ill patients," *App.* 10a, a claim that remains alive before this Court. *See infra* at 9-10.

Oregon also makes the unabashed claim that "[n]o credible argument can be made on this record that Ms Elsner is imminently in danger of suicidal depression ... that would cause her to obtain a lethal prescription under Measure 16." *Or. Br.* at 15. The trial court found she has a history of recurring "clinical depression that result[s] in ambivalence about whether she want[s] to continue living." *App.* 59a-60a (discussed at *Pet.* at 16-17). Oregon's effort to vitiate this finding and evidence by stating that Janice said "she couldn't foresee herself seeking a physician-assisted death under any scenario," *Or. Br.* at 15, misses the point. Janice's concern is that in the midst of one of her recurring suicidal depressions she would seek assistance in suicide—against her present will and intent—and because of lowered standards and lack of safeguards she would be assisted to her death. She is entitled to the same

protection against this individualized threat as other Oregonians.[6]

IV. The health care providers have standing.

The health care provider Petitioners face criminal, civil, and disciplinary penalties if they refuse to facilitate suicide under Measure 16. *Pet.* at 26-30. In violation of their religious beliefs and moral convictions, Measure 16 commands them to: a) aid in suicide or permit it on their premises; b) associate with and allow within their organizations physicians who aid suicides; c) transfer patient records to doctors willing to aid suicides; d) provide witnesses to written directives for aid in suicide; and e) inform patients of their "right" to assisted suicide (as part of their legal duty to give treatment options).

The State's glib response is that Petitioners' "claim might have merit if they could identify some provision in Oregon's criminal code imposing criminal penalties on a physician or health care provider for refusing to transfer a patient's records, refusing to advise the patient of available medical procedures, and so on." *Or. Br.* at 21. This response is misleading and inadequate.

First, Petitioners *have* identified criminal provisions applicable to health care providers refusing to comply with Measure 16. *Pet.* at 27 (citing Or. Rev. Stat. § 161.555(3); Measure 16, § 4.02(4)). The State argues that the "obvious point" of § 4.02(4) is to subject physicians who *aid* in suicide to criminal penalties if they do not comply with "the requisite procedures" of Measure 16, namely, a "terminal diagnosis, a properly witnessed request, waiting periods, [and] second physician assessment." *Or. Br.* at 20-21. But Oregon gives no reason why § 4.02(4) does not also subject physicians to criminal penalties if they do not abide by other "requisite proce-

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[6]Oregon asserts that Janice "could not identify any injury she has suffered due to Measure 16." *Or. Br.* at 6. She has clearly identified several as evidenced in her *Third Amended Complaint* (*see, e.g.*, ¶¶ 7, 31, 52), including the threat of present, stigmatic injury discussed *supra* at 3-4. Also, the State's notion that because she was opposed to Measure 16 before passage, *Or. Br.* at 6, she is somehow not now a credible plaintiff is ludicrous. Janice was opposed to Measure 16, then as now, because she views it as a threat to herself and similarly vulnerable persons. *Third Amended Complaint* at ¶ 7.

dures" of Measure 16—such as those that require transfer of patient records, providing witnesses, complying with informed consent formalities, and permitting assisted suicide on their premises. Although such conduct is not defined as a specific criminal offense like murder or assault, Oregon law states that "[a]n offense defined by a statute of this state, but without specification as to its classification or as to the penalty authorized upon conviction, shall be considered a Class A misdemeanor," a statute to which the State and other Respondents studiously avoid reference. Or. Rev. Stat. § 161.555(3). Here, for example, a failure to transfer records *is* defined as an offense because that is one of the "requisite procedures" of Measure 16.

Second, none of the Respondents dispute the other, non-criminal injuries with which the Petitioners are presently and imminently threatened. Failure to comply with Measure 16 subjects Petitioners to disciplinary sanctions, including suspension and loss of licensure. *Pet.* at 29; Or. Rev. Stat. §677.190.[7] Measure 16 subjects Petitioners to malpractice liability. *Pet.* at 26-28; Measure 16, § 4.02(3), *App.* 31a ("Nothing in [Measure 16] limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person"). Measure 16 bars Petitioners, in contravention of their religious beliefs, from censuring, disciplining, or rescinding the privileges of any doctor who assists in a suicide on their premises. *Br. Amici Curiae of U.S. Cath. Conf. et al.* at 8. Thus, there is a direct, immediate infringement on Petitioners' associational and free exercise rights. "There can be no clearer example of an intrusion into the internal structure or affairs of an association than a regulation that forces the group to accept members it does not desire." *Roberts v. U.S. Jaycees*, 468 U.S. 609, 623 (1984). Such an the intrusion is effected by Measure 16 when it requires Petitioners to associate with, and allow in their organizational ranks, physicians who aid

---

[7]Were it not for Measure 16, there would be no duty to inform patients of their "right" to assisted suicide, simply because no such "right" would exist. To suggest, as the Ninth Circuit did, that petitioners should have challenged Oregon's informed consent statute instead of Measure 16, ignores the ultimate source of petitioners' injury.

in suicides.

V. Drs. Lee & Petty have jus tertii standing.

Like the Petitioners with acknowledged jus tertii standing in *Glucksberg*, who "occasionally treat suffering, terminally ill patients," 117 S. Ct. at 2261, Drs. Lee and Petty properly assert the rights of their terminally ill patients to challenge Measure 16.

First, Drs. Lee and Petty themselves suffer injury as the result of Measure 16. Failure to abide by the various requirements imposed by Measure 16 on attending physicians when treating terminally ill patients would render them criminally and civilly liable. Second, the physician-patient relationship plainly warrants jus tertii standing here, as in *Glucksberg*. The relationship of attending physicians to patients who suffer both immediate, stigmatic injury and proximate future harm as the result of state-sanctioned assisted suicide is as least as significant as any relationship between physicians and patients seeking assisted suicide. Third, there are significant obstacles to patients asserting their own rights and interests. Prognosis of a terminal condition is uncertain and a mooted case threatens truly terminally ill persons. These difficulties are evident in this case. Plaintiff Dutson died before his claim was heard. Petitioner Elsner is said to be improperly before this Court because she has lived too long and it isn't certain she will die soon enough. Unless physicians may represent terminally ill patients, patients' rights may be violated with impunity by statutory schemes like Measure 16.

Petitioners Lee and Petty thus properly assert the rights of their terminally ill patients. *See Powers v. Ohio*, 499 U.S. 400, 411 (1991); *Singleton v. Wulff*, 428 U.S. 106, 112-116 (1976).

CONCLUSION

The petition should be granted.

Respectfully submitted,

James Bopp, Jr.
Counsel of Record
Richard E. Coleson
Thomas Alderman

September 11, 1997

(8)

Supreme Court, U.S.
FILED
SEP 11 1997
CLERK

No. 96-1824

In the
Supreme Court of the United States
October Term, 1996

GARY LEE, M.D., individually and on behalf of his terminally ill patients; WILLIAM PETTY, M.D., individually and on behalf of his terminally ill patients; JANICE ELSNER, individually and as representative of a class of terminally ill patients; et al.,

Petitioners,

v.

F. DOUGLASS HARCLEROAD, et al.,

Respondents.

On Petition for a Writ of Certiorari to the
United States Court of Appeals for the Ninth Circuit

REPLY TO RESPONSES TO MOTION TO DEFER CONSIDERATION OF PETITION FOR A WRIT OF CERTIORARI

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31pp

LIST OF CORPORATIONS

The Willows Home, Inc. has no parent company and no subsidiaries.

The parent company of Maryville Nursing Home, Inc. is Sisters of St. Mary of Oregon, an Oregon nonprofit religious corporation. Maryville Nursing Home, Inc. has no subsidiaries.

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REPLY IN SUPPORT OF MOTION TO DEFER

On June 23, 1997, Petitioners filed their *Motion to Defer Consideration of Petition for a Writ Of Certiorari* with this Court. The Motion was occasioned by the Oregon Legislative Assembly's passage of a statute that places Oregon Ballot Measure 16 — the law challenged by the Petitioners — before Oregon voters for possible repeal by referendum on November 4, 1997. Petitioners argued that this Court should defer consideration of their *Petition* until after the November referendum because of an imminent future event that might render the *Petition* moot.

No response to Petitioners' *Motion to Defer Consideration* was filed by any of the Respondents within ten days of the motion, i.e., by July 3, 1997, as required by Supreme Court Rule 21.4. Therefore, Respondents have waived the right to object to the *Motion to Defer Consideration*, and no arguments by Respondents against the *Motion to Defer Consideration* should be considered in deciding Petitioners' *Motion to Defer Consideration*.

Both Respondent State of Oregon and Respondents Levin and Shuck commented on the *Motion to Defer Consideration* in their briefs in opposition to the *Petition*. *Or. Br.* at 23 & n.13; *Levin Br.* at 4. These comments were in the nature of an untimely response to the *Motion to Defer Consideration*, and Petitioners Janice Elsner et al. hereby reply in order to: 1) object to the comments and 2) rebut them, in the event this Court considers them.

I. Deferral of consideration of the *Petition* would not provide political advantage to proponents or opponents of repeal.

Oregon asserts that "[d]elaying a ruling on the petition until after the November 4, 1997, referral may provide plaintiffs and other opponents of Measure 16 with a political

advantage in the form of on-going uncertainty about the constitutionality of the law." *Or. Br.* at 23 n. 13.[1] (The State does note that the Petitioners "properly do not rely on that as a basis to urge the Court to delay a ruling on the petition, however." *Id.*) Oregon's claim is erroneous for two reasons.

First, even if this Court denies the *Petition*, the substance of Petitioners' constitutional claims against Measure 16 will remain intact and potentially justiciable.[2] Moreover, the district court opinion in *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), holding Measure 16 unconstitutional on equal protection grounds, will not have been reversed on the merits of the Petitioners' underlying constitutional claims. *See, e.g., United States v. Carver*, 260 U.S. 482, 490 (1923) ("denial of a writ of certiorari imports no expression upon the merits of the case"). Thus, "on-going uncertainty about the constitutionality of the law" will continue to exist even if this Court denies certiorari, as the Respondents argue that it should.

Similarly, if certiorari should be granted, then the present uncertainty will continue unabated.

Since the uncertainty over the constitutionality of Measure 16 would not be resolved by immediate consideration of the *Petition*, whatever the outcome, Oregon's argument against deferral in order to dispel constitutional uncertainty makes no sense.

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[1]Oregon also argues that deferral would serve no purpose because the "petition does not present the Court with a legal question of importance." *Or. Br.* at 23. This claim is fully answered in Petitioners' *Reply to Briefs in Opposition* filed with this Court on September 12, 1997, and need not be addressed here.

[2]This Court retained scrupulous neutrality as to the constitutionality of Measure 16 when discussing the present case in *Washington v. Glucksberg*. 117 S. Ct. 2258, 2262 n.7, 2266 & n. 14 (1997).

Second, Oregon simply presumes that political proponents of repeal are served by continuing "constitutional uncertainty" that prevents Measure 16 from taking effect. It might just as easily be the case, however, that Oregon voters would be *more* inclined to reject Measure 16 if the law took effect and assisted suicides actually began to be performed under its auspices.

In any event, Oregon's presumption underscores the essentially political nature of the decision that this Court would be required to make based on the Oregon's argument: Oregon asks the Court not to defer consideration of the *Petition* based purely on an estimate of how the voters may react to maintaining the status quo. In contrast, Petitioners Elsner et al. maintain that deferral is appropriate for jurisprudential reasons relating to judicial economy and potential mootness. *Motion to Defer Consideration* at 2-3 (and cases and authority there cited).

The brief in opposition to the *Petition* by Goodwin, Coombs Lee, and Sinnard makes no mention of the *Motion to Defer Consideration*, and these Intervenor Respondents have not responded and now cannot respond to Petitioners' *Motion to Defer Consideration*. Supreme Court Rule 21.4. Respondents Goodwin, Coombs Lee, and Sinnard are the three chief petitioners who originally sponsored Measure 16 in 1994. Presumably, they would be most disturbed by any political advantage that deferral might gain for the proponents of Measure 16 repeal, yet they have neither argued that deferral would shift the political balance nor even filed a response to the *Motion to Defer Consideration*.

Intervenor Respondents Levin and Shuck are or represent persons unable to secure assisted suicide as the result of this court action. Yet they did not file a response to the

Motion to Defer Consideration. In their *Brief in Opposition* they do note that Oregonians might soon "lose interest" in this challenge "because the law itself may go away or change form in the near future" by virtue of the referendum or legislative amendment, and they ask for no delay "until after the November plebiscite." *Levin Br.* at 2-4. However, Petitioners Elsner et al. argue for deferral precisely *because of* the mootness that Respondents Levin and Shuck suggest is imminent.

II. Prudential considerations support maintaining the status quo by deferring a decision pending prompt political resolution of this matter.

Deferral would serve the interest of judicial economy by postponing a decision which may not need to be made. This Court's valuable resources ought not to be expended on a matter that may be moot in such a short amount of time, especially when all that is required is a brief postponement of the usual conferencing time for the *Petition*.

Moreover, any decision to accept or refuse the Petition would now take place squarely in the midst of the legal process begun after the Oregon Legislative Assembly voted to submit Measure 16 to Oregon voters to repeal or retain by referendum. After the Assembly enacted Enrolled Oregon House Bill 2954, which referred Measure 16 to the voters (*Motion to Defer Consideration of Petition for a Writ of Certiorari, Exhibit A*), the Assembly prepared a ballot title pursuant to Or. Rev. Stat. § 250.075(1) (1995). The ballot title was vetoed by the Governor, and the Attorney General prepared a ballot title pursuant to Or. Rev. Stat. § 250.075(2).

Several electors disputed the process and language of the ballot title and submitted the matter to the Oregon Supreme Court pursuant to Or. Rev. Stat. § 250.085. The Court issued

a final opinion on the language of the ballot title on September 2, 1997. *See Hamilton v. Meyers*, Nos. S44434, S44454 (Or. Sup. Ct. Sep. 2, 1997), attached hereto as *Exhibit A*.

This referendum is being conducted by mail and, in accord with the extensive procedures required under Oregon law for initiatives and referenda (Or. Rev. Stat. § 250.005 to § 250.355 (1995)), the entire process for conducting a referendum is now well under way. *See Timelines for the November 4, 1997 Special Election by Mail*, issued by the Oregon Secretary of State, attached hereto as *Exhibit B*.

Thus, the Secretary of State certified the official ballot to county election officials on September 9, 1997. *Id.* at (q). Mail ballots will be sent to long-term absentee voters by September 20, 1997. *Id.* at (r). An explanatory pamphlet (which includes the language of the ballot title, an official explanatory statement, the statute authorizing the referendum, and pro/con arguments submitted by proponents and opponents of repeal) must be "delivered to [Oregon] households not sooner than October 8, 1997, and not later than October 11, 1997." *Id.* at (s). Ballots must be mailed to non-absentee voters "not sooner than October 15, 1997 and not later than October 17, 1997." *Id.* at (t). All ballots must be returned by voters to the State by no later than 8:00 p.m. on Tuesday, November 4, 1997, to be counted as valid. Ballots may be returned by mail or in drop-boxes provided in some locations.

Obviously, the political debate that attends this legal process is also well underway. The campaigns for and against retention of Measure 16 must parallel and be based, at least in part, upon the legal milieu created by the nature of the language of the ballot title, the nature of the explanatory pamphlet being provided to the voters, and the present status of this litigation.

For this Court to rule either to grant or deny the Petition at this time would in effect introduce an unknown, potentially unsettling factor into on-going legal and political processes that will be over in less than two months. Prudential considerations arising from appropriate judicial deference to legislative and political aspects of governance and from federal-state comity suggest that the status quo should be maintained by deferring consideration of this Petition until the referendum has been conducted.[3] If the states are the laboratories of democracy, then the federal judiciary ought to at least wait to test the outcome of an experiment until it had been completed.

In its recent opinions rejecting a constitutional right to assisted suicide, this Court left the matter with the States to resolve (in a constitutionally permissible manner, of course). *See, e.g., Washington v. Glucksberg*, 117 S. Ct. 2258, 2275 (1997). As Oregon engages in the struggles which characterize representative and democratic lawmaking, the most neutral position this Court could take would be to remain above the fray by simply permitting the status quo to continue while the Nation watches to see if Oregon really wants legalized assisted suicide after all.

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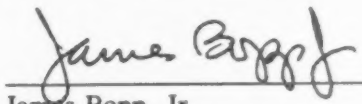
[3]Historically, the status quo in Oregon has been that assisted suicide is illegal for all. Because Measure 16's implementation has remained enjoined by federal court order for nearly three years, the status quo has remained that assisted suicide is illegal for all in Oregon.

CONCLUSION

For the foregoing reasons, the Court should grant the *Motion to Defer Consideration of Petition for a Writ of Certiorari* and defer conferencing the present case until after the results of the November 4, 1997, referendum are certified and the Court is notified by the Petitioners of the results.

Respectfully submitted,



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Filed: September 12, 1997

Filed: September 2, 1997

IN THE SUPREME COURT OF THE STATE OF OREGON

N. GREGORY HAMILTON, M.D., KENNETH STEVENS, M.D., SPEAKER LYNN LUNDQUIST, REP. LYNN SNODGRASS, and REP. RON SUNSERI,

Petitioners,

v.

HARDY MYERS, Attorney General, State of Oregon

Respondent.

PETER GOODWIN, M.D., BARBARA COOMBS LEE, ESQ., and ELVEN SINNARD,

Petitioners,

v.

HARDY MYERS, Attorney General for the State of Oregon,

Respondent.

(SC S44434, S44454)
(Consolidated for argument and opinion)

In Banc

On petitions to review ballot title.

Argued and submitted August 26, 1997.

Richard M. Botteri, of Preston Gates & Ellis LLP, Portland, argued the cause and filed the petition for petitioners N. Gregory Hamilton, M.D., et al. With him on the petition was Kelly Cole Zerzan.

Eli D. Stutsman, Portland, argued the cause and filed the petition for petitioners Peter Goodwin, M.D., et al.

Exhibit A

David Schuman, Deputy Attorney General, and Richard D. Wasserman, Assistant Attorney General, Salem, argued the cause for respondent. With them on the answering memoranda was Virginia L. Linder, Solicitor General.

GILLETTE, J.

Ballot title certified. Pursuant to ORAP 1.20(4) and notwithstanding ORAP 11.30(10), this opinion will become effective when the appellate judgment issues. The State Court Administrator shall issue the appellate judgment at 4:00 p.m. on September 5, 1997, unless a petition for reconsideration is both filed with and physically received by the Office of the State Court Administrator by that time. A timely petition for reconsideration will stay issuance of the appellate judgment until the court acts on all timely petitions for reconsideration.

DESIGNATION OF PREVAILING PARTY AND AWARD OF COSTS

Prevailing party: None

[X] No costs allowed.
[ ] Costs allowed, payable by:
[ ] Costs allowed, to abide the outcome on remand, payable by:

GILLETTE, J.

These are consolidated proceedings for review of a ballot title that the Attorney General has certified to the Secretary of State for a measure that the 1997 Legislative Assembly has referred to the people. That measure, designated by the Secretary of State as "Measure 51," would, if enacted, repeal ORS 127.800 to 127.897, the "Oregon Death with Dignity Act." That Act (hereafter sometimes referred to as "Measure 16") was itself adopted by the people at the November 1994 general election but, due to various court proceedings, never has gone into effect. Petitioners[1] are electors who filed timely written comments with respect to various aspects of the ballot title as it originally was proposed by the Attorney General and who now are entitled to maintain these proceedings. See ORS 250.085(2) (establishing the foregoing criteria for standing to challenge ballot titles certified by the Attorney General).

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[1] There are two petitions for review of the ballot title and two sets of petitioners. In case #S44434, the petitioners, referred to hereafter as "Hamilton et al.," are Hamilton and Stevens, who are physicians, and Lundquist, Snodgrass, and Sunseri, who are members of the Legislative Assembly. In case #S44454, the petitioners, referred to hereafter as "Goodwin et al.," are Goodwin, a physician, Lee, a lawyer and nurse, and Sinnard. The latter set of petitioners were the principal sponsors of Measure 16.

Pursuant to ORS 250.067(2), the Attorney General has certified to the Secretary of State the following ballot title for the referred measure:

"REPEALS LAW ALLOWING TERMINALLY ILL ADULTS TO OBTAIN LETHAL PRESCRIPTION

"RESULT OF 'YES' VOTE: 'Yes' vote repeals law allowing terminally ill adults to obtain physician's prescription for lethal drugs.

"RESULT OF 'NO' VOTE: 'No' vote retains law allowing terminally ill adults to obtain physician's prescription for lethal drugs.

"SUMMARY: Repeals Measure 16, adopted by voters in 1994. That law:

"Allows terminally ill adult Oregon residents voluntary informed choice to obtain physician's prescription for lethal drugs when physicians predict patient's death within 6 months;

"Requires 15-day waiting period; 2 oral, 1 written request; second physician's opinion; counseling for patients with impaired judgment from depression;

"Gives health care providers immunity from civil, criminal liability for good faith compliance.

"Permits person choice whether to notify next of kin.

"Allows health care providers to refuse to participate."

This court reviews ballot titles certified by the Attorney General to determine whether such titles comply

substantially with the requirements of ORS 250.035(2).[2] ORS 250.085(5). Before turning to those requirements, however, we first must address a procedural point raised by petitioners Hamilton et al.

Petitioners Hamilton et al. argue to this court, as a preliminary matter, that the Attorney General was precluded from preparing a ballot title for the proposed measure, because the Legislative Assembly had itself prepared a ballot title for the measure. See ORS 250.075(1) (providing that, "[w]hen the Legislative Assembly refers a measure to the people, a ballot title for the measure may be prepared by the assembly") (emphasis added). It follows, they argue, that the Attorney General had no authority to prepare a separate, substitute ballot title. See ORS 250.075(2) (providing that, "[i]f the [ballot] title is not prepared under subsection (1) of [ORS 250.075]," the Attorney General shall prepare a ballot title for the referred measure) (emphasis added). From the foregoing, petitioners reason that this court is precluded from reviewing the Attorney General's ballot title, because that ballot title is not eligible to be placed on the ballot at all in any form, i.e., is a

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[2] The specific requirements for a ballot title under ORS 250.035(2) are identified and discussed later in this opinion.

nullity.

Petitioners acknowledge that A-Engrossed House Bill 3502 (1997 session), the bill that purported to create the legislature's suggested ballot title, was vetoed by the Governor. They assert, however, that the gubernatorial veto also was a nullity, because the Governor is without power to veto legislative bills that are referred to the people. Because this latter theory is pivotal to petitioners' argument, we turn to it.

It is true, as petitioners state, that the Governor does not have the power to veto bills referred to the people by the Legislative Assembly. Oregon Constitution, Article IV, section 1(3)(c).[3] But A-Engrossed House Bill 3502 (1997 session) itself was not, by its own terms, a referred bill. Instead, it was a direction to the Secretary of State to use the election machinery of state government to place before the voters a particular ballot title for a referred bill that had been created in a separate bill, A-Engrossed House Bill 2954 (1997 session).

---

[3] Oregon Constitution, Article IV, section 1(3)(c), provides:

> "A referendum on an Act may be ordered by the Legislative Assembly by law. Notwithstanding section 15b, Article V of this Constitution, bills ordering a referendum and bills on which a referendum is ordered are not subject to veto by the Governor."

As such, A-Engrossed House Bill 3502 (1997 session) was not, as the constitution specifies, a "bill[] ordering a referendum" or a "bill[] on which a referendum is ordered" but was, instead, a bill like any other bill for an Act: It could become law only if a majority of each house of the Legislative Assembly concurred in it, Or Const, Art IV, § 25, and if it was not vetoed by the Governor, Or Const, Art V, § 15b. In the case of A-Engrossed House Bill 3502 (1997 session), however, the Governor chose to exercise his veto power under Oregon Constitution, Article V, section 15b. A-Engrossed House Bill 3502 (1997 session) thus never became law. As of this date, the Legislative Assembly has not overridden his veto pursuant to Oregon Constitution, Article V, section 156(2).

No ballot title having been created by the Legislative Assembly for Measure 51 (i.e., A-Engrossed House Bill 3502 (1997 session) never having become an Act), it fell to the Attorney General to create a ballot title. ORS 250.075(2). The Attorney General did so. The present proceedings are validly before this court. We turn to the merits of the arguments presented by the various petitioners.

As noted, this court reviews ballot titles for "substantial compliance" with the statutory requirements in ORS

250.035. ORS 250.085(5). ORS 250.035(2) provides:

> "The ballot title of any state measure to be initiated or referred shall consist of:
>
> "(a) A caption of not more than 10 words that reasonably identifies the subject matter of the state measure. * * * ;
>
> "(b) A simple and understandable statement of not more than 15 words that describes the result if the state measure is approved. * * *;
>
> "(c) A simple and understandable statement of not more than 15 words that describes the result if the state measure is rejected. * * *;
>
> "(d) A concise and impartial statement of not more than 85 words summarizing the measure and its major effect."

Petitioners Goodwin et al. and Hamilton et al. mount separate challenges to the Caption, Result Statements, and Summary of the certified ballot title. We address each of the three sections of the ballot title in order.

THE CAPTION

Petitioners Goodwin et al. argue that the Caption of the certified ballot title fails to "reasonably identify the subject matter" of Measure 51, as required by ORS 250.035(2)(a), because, instead of focusing on the present measure, it relies too heavily on the ballot title wording certified in 1994 for the then-proposed Measure 16. Specifically, they argue that the

subject matter of Measure 51 would be more readily identifiable if the Caption were to refer, by name and year of passage, to the law that Measure 51 proposes to repeal. They propose a Caption stating: "REPEALS DEATH WITH DIGNITY ACT PASSED BY VOTERS IN 1994."

That argument is not well taken. Assuming that the foregoing would be a permissible Caption, nothing in petitioners' argument demonstrates how the Attorney General's alternative choice for the Caption, viz., "REPEALS LAW ALLOWING TERMINALLY ILL ADULTS TO OBTAIN LETHAL PRESCRIPTION," fails to meet the standard imposed by ORS 250.035(2)(a). The certified Caption reasonably identifies the subject matter of Measure 51 by referring to the content of the corresponding law that it seeks to repeal, using wording previously approved by this court to describe the subject matter. See Kane v. Kulongoski, 318 Or 593, 871 P2d 993 (1994) (issuing certified ballot title for the 1994 initiative; certified Caption read: "ALLOWS TERMINALLY ILL ADULTS TO OBTAIN PRESCRIPTION FOR LETHAL DRUGS").

For similar reasons, the arguments of petitioners Hamilton et al. with respect to the Caption fail. They argue that the certified Caption is inadequate, because it leaves out any reference to "drugs" as the medium through which lethal

prescriptions may be made under the law, in favor of adding the term "adult." They propose that this court substitute the Caption that the legislature proposed in HB 3502 (1997). That Caption states: "REPEALS LAW ALLOWING PRESCRIPTION OF LETHAL DRUGS TO TERMINALLY ILL." By including the term "drugs," petitioners assert, this Caption includes what they deem to be the "most significant" aspect of the law that Measure 51 seeks to repeal, i.e., the right of a physician to write a prescription for lethal drugs.

Petitioners' argument is only an assertion that their preferred wording would be "better" than that used by the Attorney General. That is no basis for this court to hold that the Attorney General's choice is legally insufficient. Moreover, inserting the word "drug" necessarily would require removing the word "adult," in order to meet the 10-word limit on captions. ORS 250.035(2)(a). The gain would not offset the loss: The concept of "drugs" is implied in the word "prescription." On the other hand, removing the word "adult" would deprive the voters of crucial information about who may seek a lethal prescription.

Petitioners have not established that the certified Caption fails to comply substantially with the requirements of ORS 250.035(2)(a).

THE RESULT STATEMENTS

The Attorney General's certified ballot title contains the following Result Statements:

> "RESULTS OF 'YES' VOTE: 'Yes' vote repeals law allowing terminally ill adults to obtain physician's prescription for lethal drugs.
>
> "RESULTS OF 'NO' VOTE: 'No' vote retains law allowing terminally ill adults to obtain physician's prescription for lethal drugs."

Petitioners Goodwin et al. argue, as they did with respect to the Caption, that the Result Statements would be more "simple and understandable," ORS 250.035(2)(b) and (c), if they clearly identified the existing law that Measure 51 seeks to repeal. We reject petitioners' arguments for the same reason expressed earlier concerning petitioners' similar argument with respect to the Caption.

Petitioners Hamilton et al. argue for the following Result Statements:

> "RESULT OF 'YES' VOTE: 'Yes' vote repeals law allowing prescription of lethal drugs for adults diagnosed as terminally ill.
>
> "RESULT OF 'NO' VOTE: 'No' vote retains law allowing prescription of lethal drugs for adults diagnosed as terminally ill."

Petitioners' proposed Result Statements are those that the legislature proposed in HB 3502 (1997 session).

These petitioners assert that the most significant feature of the existing law is that it removes criminal penalties for physicians who prescribe lethal drugs to the terminally ill. Therefore, they reason, their proposed Result Statements properly shift the focus from the choice that the law provides to terminally ill adults to what the law allows physicians to do. Petitioners offer one way to look at the existing law, but their argument fails to show why the certified ballot title, which roughly parallels the 1994 ballot title for Measure 16, does not comply substantially with the requirements of ORS 250.035(2)(b) and (c). Moreover, by maintaining the same focus as the Caption, the certified Result Statements are in accord with this court's case law endorsing internal consistency in ballot titles. See Mabon v. Keisling, 317 Or 406, 414, 856 P2d 1023, (1993) (Question -- statutory predecessor to the Result Statements -- should build on and be consistent with the Caption); Kane, 318 Or at 600 (rewording Caption to make it consistent with the Question and Summary).

THE SUMMARY

The Summary must contain "[a] concise and impartial statement of not more than 85 words summarizing the measure and

its major effect." ORS 250.035(2)(d). In addition to urging that the use of the phrase, "Oregon Death with Dignity Law," in the Summary is essential -- an argument that we reject for the reason already stated -- petitioners Goodwin et al. challenge certain wording of the certified Summary. They argue that the phrase, "Repeals Measure 16, adopted by voters in 1994," is misleading and biased, because the "Death With Dignity Act" no longer is merely a "measure" but, instead, has been transformed into a "law" by the vote of the people. The voters, petitioners assert, are entitled to know that Measure 51 seeks to repeal an existing law.

The Attorney General's certified Summary, although it begins with a reference to "Measure 16," almost immediately thereafter refers to that measure as "[t]hat law." (Emphasis added.) That reference is sufficient, we conclude, to convey to the voters the fact that they are dealing with an existing law.

Petitioners Hamilton et al. reject the entire Summary certified by the Attorney General. They first argue that the certified Summary is unfair, because it informs the voters that Measure 51 would repeal a measure that passed in 1994, thereby making a "political statement" that "encourag[es] voters to vote against Measure 51." We are not persuaded. We agree with the

Attorney General that telling the voters what year the existing law passed is one permissibly useful, neutral method of helping to identify the existing law.

As a fallback position, petitioners argue that the voters at least also deserve to be told that the 1994 initiative passed by a "slim" margin and that the legislature referred the law back to the voters because of its "flaws." Neither of those suggestions is well taken. The margin of passage of Measure 16 is a matter for argument, not for inclusion in an impartial Summary. Still less is it appropriate for a Summary to take sides with respect to a measure by announcing that, in the opinion of some members of the Legislative Assembly, the measure has "flaws."

Petitioners Hamilton et al. next argue that the certified Summary is inadequate, because it improperly focuses on what the 1994 law does, rather than on the "major effect" of Measure 51. The major effect of Measure 51, petitioners assert, is simply to repeal a law; no more needs to be said. They offer the following Summary:

> "SUMMARY: This measure repeals the law that allows terminally ill adults to obtain physician's prescription to commit physician-assisted suicide."

That proposed Summary is the one proposed by the legislature in

HB 3502 (1997 session).

Petitioners' proposed Summary makes no effort to inform the voters of the features of the existing law -- opting to explain only one part (the repeal) of a two-part story (existing law). Even if that would be a permissible way to draw a ballot title in these circumstances -- an issue that we need not and do not address -- petitioners have offered no persuasive explanation as to why the Attorney General's decision to tell both parts of the story fails to comply with the statutory directive to include a Summary containing an impartial statement summarizing the measure's major effect. ORS 250.035(2)(d).

Petitioners Hamilton et al. argue next that the use of the term "residents" in the Summary is improper, because that term is not defined. This court certified a similar use of the term in Kane, the ballot title review case for the 1994 initiative (Measure 16). Petitioners fail even to address, much less explain, why the Kane court erred in using that term.

Petitioners Hamilton et al. rely on federal cases in an attempt to illustrate what they consider to be deficiencies in the certified Summary. They argue first that the reference in the Summary to the standard for criminal and civil immunity is improper, because it has been held unconstitutional. See Lee v.

State of OR, 891 F Supp 1421 (D Or 1995); Lee v. State of OR, 891 F Supp 1429 (D Or 1995) (both so holding). However, the Lee cases were vacated by the Ninth Circuit. Lee v. OR, 107 F3d 1382 (9th Cir 1997). Moreover, and whether or not vacated, such cases have no precedential authority.

Petitioners Hamilton et al. also challenge the use in the Summary of the phrase, "voluntary informed choice," citing the United States Supreme Court's expressed skepticism of such "safeguards" in Washington v. Glucksberg, ___ US ___, ___ S Ct ___, ___ L Ed 2d ___, 65 USL W 4669 (June 24, 1997). Glucksberg is not helpful to the present proceeding. That case addressed the issue of a terminally ill adult's right, under the United States Constitution, to commit physician-assisted suicide, in jurisdictions in which such an act had been declared criminal. Glucksberg does not change the content or meaning of Oregon's existing law.

We conclude that the Attorney General's Summary substantially complies with the requirements of law.

In conclusion, we hold that the ballot title certified by the Attorney General to the Secretary of State is not legally deficient in any respect urged by any of the petitioners before us. Accordingly, we certify the following ballot title for

Measure 51:

REPEALS LAW ALLOWING TERMINALLY ILL ADULTS TO OBTAIN LETHAL PRESCRIPTION

RESULT OF "YES" VOTE: "Yes" vote repeals law allowing terminally ill adults to obtain physician's prescription for lethal drugs.

RESULT OF "NO" VOTE: "No" vote retains law allowing terminally ill adults to obtain physician's prescription for lethal drugs.

SUMMARY: Repeals Measure 16, adopted by voters in 1994. That law:

Allows terminally ill adult Oregon residents voluntary informed choice to obtain physician's prescription for lethal drugs when physicians predict patient's death within 6 months;

Requires 15-day waiting period; 2 oral, 1 written request; second physician's opinion; counseling for patients with impaired judgment from depression;

Gives health care providers immunity from civil, criminal liability for good faith compliance.

Permits person choice whether to notify next of kin.

Allows health care providers to refuse to participate.

Ballot title certified. Pursuant to ORAP 1.20(4) and notwithstanding ORAP 11.30(10), this opinion will become effective when the appellate judgment issues. The State Court Administrator shall issue the appellate judgment at 4:00 p.m. on September 5, 1997, unless a petition for reconsideration is both

filed with and physically received by the Office of the State Court Administrator by that time. A timely petition for reconsideration will stay issuance of the appellate judgment until the court acts on all timely petitions for reconsideration.

DIVISION 007

CONDUCT OF ELECTIONS

Timelines for the November 4, 1997 Special Election by Mail

165-007-0220 (1) The purpose of this rule is to establish the necessary timelines for the Secretary of State and county election officials to conduct a vote-by-mail election and produce a state voters' pamphlet for two statewide measures (House Bill 2954 and Senate Bill 346) referred by the 1997 Legislative Assembly to be voted on at a special election to be held throughout the state on November 4, 1997.

(2) Except where otherwise indicated, "filed" means delivered to and actually received in the office of the Secretary of State, Elections Division, not later than 5:00 p.m. on the designated filing deadline date.

(3) The official timelines for the conduct of the statewide special election on November 4, 1997 shall be as follows:

(a) Written comments concerning a draft ballot title shall be filed not later than five business days after the draft ballot title is filed with the Secretary of State by the Attorney General;

(b) The Attorney General shall file a certified ballot title not later than three business days after the deadline for filing written comments on the draft ballot title;

(c) Any person who timely filed written comments on a draft ballot title, who wishes to appeal the certified ballot title, shall file a petition with the Supreme Court not later than three business days after the Attorney General certifies the ballot title to the Secretary of State;

(d) The Senate President and Speaker of the House shall each appoint one measure proponent to the explanatory statement committee not later than July 24, 1997;

(e) The Secretary of State shall appoint two measure opponents and, if no proponents have been appointed, two proponents, to the explanatory statement committee not later than July 24, 1997;

(f) The four explanatory statement committee members shall appoint a fifth member not later than July 30, 1997;

(g) If the four explanatory statement committee members fail to appoint a fifth member, the Secretary of State shall appoint a fifth member not later than July 31, 1997;

(h) Drafts of the explanatory and financial impact statements shall be filed not later than August 6, 1997;

(i) Public hearings for the draft explanatory and financial impact statements shall be conducted not sooner than August 7, 1997 and not later than August 8, 1997;

(j) The financial impact statement committee shall consider changes and may file revised estimates not later than August 14, 1997;

(k) The Secretary of State shall prepare, certify and file the financial impact statement, if two or more committee members do not approve the committee's estimates, not later than August 15, 1997;

(l) Final explanatory statements shall be filed not later than August 15, 1997;

(m) Legislative Counsel explanatory statements shall be filed not later than

Exhibit B

August 15, 1997;

(n) Any appeal of the explanatory or financial impact statements shall be filed with the Supreme Court not later than August 20, 1997;

(o) Measure arguments to be included in the state voters' pamphlet shall be filed not later than August 26, 1997;

(p) Legislative arguments in support of each measure to be included in the state voters' pamphlet shall be filed not later than August 26, 1997;

(q) The Secretary of State shall certify the official ballot to county election officials not later than 5:00 p.m., September 9, 1997;

(r) County election officials shall mail ballots to long-term absent electors (overseas and military) not later than September 20, 1997;

(s) The state voters' pamphlet shall be delivered to households not sooner than October 8, 1997 and not later than October 11, 1997.

(t) County election officials shall mail ballots to other than long-term absent electors not sooner than October 15, 1997 and not later than October 17, 1997.

Statutory Authority: ORS 246.120, 246.150, House Bill 3742 (1997 Legislative Assembly)

Stats. Implemented: ORS 250.127, 251.205, 251.215, 251.225, 251.235, 251.245, House Bill 3742 (1997 Legislative Assembly)